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A Mixed Methods Evaluation of the Experiences of Adults

with Learning Disabilities and Anxiety Undertaking

Compassion Focussed Therapy

‘Compassion is a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it’

The Dalai Lama

(Gilbert, 2010a)

Abstract

In the UK approximately 1.2 million people are estimated to have a mild to moderate learning disability (LD); however, they are historically underrepresented in research. Whilst there's a small but growing evidence base for Compassion Focussed Therapy (CFT) in adult populations, there's no published research regarding its use with people with LD.

A mixed methods case study project explored the experience of three participants with LD and anxiety undertaking a programme of CFT. Measures of self-compassion, anxiety and depression were administered pre-intervention, post-intervention and at three-month follow-up. Post-intervention interviews were analysed using interpretative phenomenological analysis. Findings were then combined to develop mixed methods inferences.

Findings showed that participant anxiety reduced significantly. Participants experienced this reduction as a categorical change in the self. There was limited evidence for overall changes in their understanding and experience of self-compassion. In addition, they appeared to understand mindfulness as a tool to use when experiencing acute distress. Participants appeared to be developing a greater sense of common humanity.

Issues raised include possible diagnostic overshadowing leading to high levels of anxiety at referral, the value of mixed methods research in the field and the value of a hermeneutic understanding of the researcher's role in analysing data from people with LD. In summary, this research is the first to examine the function of CFT in adults with LD. It suggests that CFT may have a role in clinical practice, but as always more research is needed.

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Degree Declaration

The work contained in this thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Counselling Psychology and represents an individual contribution by the author.

None of this work has been previously submitted by the author for a degree of this or any other university.

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Chapter 1. Introduction

This thesis will examine the experience of people with learning disabilities and anxiety who undertake a course of compassion focussed therapy. Solely for the purposes of defining the key terms that will be encountered throughout the thesis, I will be adopting a pluralistic epistemological position in this chapter. The research project itself will then adopt a pragmatic epistemology (see section 3.3). Pluralism sits at the heart of modern Counselling Psychology practice (Athanasiadou, 2012). It was offered as an epistemological framework for counselling practice by Cooper & McLeod (2007), citing Rescher (1993) to define its key assumption as ‘the doctrine that any substantial question admits of a variety of plausible but mutually conflicting responses’. In other words, any problem can be understood and explored from more than one perspective, and those perspectives need not be reconcilable. As an approach to applied counselling psychology practice, this would suggest that the most functional therapeutic approach to adopt with a particular client and particular problem at a particular time might be drawn from any one of a number of different therapeutic models. From a pluralistic perspective individual models of therapy can offer different and incompatible views of a problem, but all still be valid and useful ways of understanding. I will therefore be specifically adopting a pluralistic approach to understanding the key terms described throughout this chapter. For instance, learning disability can be understood from a medical model or social model of disability approach. Both offer valid and useful insights and it need not be necessary to attempt to integrate them into a single shared understanding of the topic.

1.1 What is a Learning Disability (LD)?

1.1.1 The Medical Model

The term 'medical model' was first defined by Laing (1971). It represents a shared epistemological and methodological approach to understanding based around seeing distress as a biological condition best suited to investigation and treatment in the same way as diseases of the body such as cancer, diabetes etc. It emphasises positivist understandings and diagnosis and is closely allied to quantitative research methodologies.

Within this perspective, learning disability (LD) is a term used to describe individuals with a significant impairment in intellectual functioning. The two major diagnostic systems both provide definitions of the condition. The Diagnostic and Statistical Manual, Version 4 (DSM-IV) (American Psychiatric Association, 1994) requires each of the following conditions to be met:

(a) Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test.

(b) Concurrent deficits or impairments in present adaptive functioning (i.e. the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas:

- communication
- self-care
- home living
- social/interpersonal skills
- use of community resources
- self-direction
- functional academic skills

- work
- health and safety.
- leisure

(c) The onset is before age 18 years.

(British Psychological Society, 2000)

The ICD-10 International Classification of Mental and Behavioural Disorders (World Health Organisation, 2010) defines it as:

... a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities.

... Adaptive behaviour is always impaired.

In the United Kingdom, the operational definition for access to services emerges from the paper 'Valuing People Now' (Great Britain, Department of Health, 2001):

Learning disability includes the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

- ... this definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need. Many people with learning disabilities also have physical and/or sensory impairments. The definition covers adults with autism who also have learning disabilities, but not those with a higher level autistic spectrum disorder who may be of average or even above average intelligence – such as some people with Asperger’s Syndrome.... ‘Learning disability’ does not include all those who have a ‘learning difficulty’ which is more broadly defined in education legislation.

For most individuals accessing services, whether they meet this definition is a decision made by health or social care professionals based on their presentation at interview and a brief history. Many people accessing services will not have a formal diagnosis of Learning Disability, although in some cases a formal diagnosis is required. The British Psychological Society (BPS) document ‘Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood’ (2015) outlines the process to be followed by psychologists conducting such assessments. Broadly, they would conduct a standardised assessment of cognitive functioning using a tool such as the Weschler Adult Intelligence Scale – Fourth UK Edition (WAIS-IV UK) (Weschler, 2010). This is capable of producing an estimate of an individual’s cognitive functioning (Full Scale IQ {FSIQ}) in comparison with a sample of UK adults. Scores are reported on a scale where 100 represents the average score produced by

age equivalent adults. The test has a standard deviation of 15 points, meaning that a score of 70 or below represents a level of performance two standard deviations below the mean. This is the standard cut-off for diagnosis of a learning disability, which if FSIQ is normally distributed would mean that approximately 2% of the adult population meet this definition.

Deficits in adaptive functioning can be assessed by formal measures such as the Adaptive Behaviour Assessment Schedule (ABAS) (Harrison & Oakland, 2008) or by interview. The ABAS groups adaptive behaviours into three clusters – Conceptual, Social and Practical skills. It is based on a sample representing the English-Speaking US population and has not been standardised with any other populations (ibid. p.59). This represents a significant limitation with this model of assessing adaptive behaviours. Age of onset can be established by review of clinical records and a clinical and educational history.

There are difficulties with this diagnostic approach relating to validity, reliability and utility. From a validity perspective, tests such as WAIS IV UK are based on the Cattell-Horn-Carroll model of intelligence and accept the existence of an overall factor for general intelligence, 'g' (O'Reilly & Carr, 2007). However, the confirmatory factor analysis for FSIQ compared the construct to four subscales of intelligence within the WAIS IV UK standardisation sample, standardised factor loadings range from 0.67 to 0.89, suggesting mixed degrees of correlation between FSIQ and specific subsections of the test. Additionally, the FSIQ cut-off of 70 has been arrived at from a statistical rather than medical or diagnostic basis. Indeed, in the USA between 1961 and 1972, the diagnostic cut-off was 85. It was later reduced to 70, removing a large percentage of people from the diagnostic category (Webb & Whitaker, 2012).

With regards to reliability, whilst WAIS-IV UK reports a point estimate of FSIQ, it more correctly provides a range of possible scores within which it is possible to be 95% confident that the true score may sit (Weschler, 2010). For an FSIQ of 70, the 95% confidence intervals are 67-75 which introduces significant doubt into marginal scores. These confidence intervals have been challenged by Whitaker (2008) who recommends broader confidence intervals of 13 points around the key diagnostic cut-off of 70.

From a utilitarian perspective, the ecological validity of FSIQ as a tool for rationing learning disability service provision has been challenged (Sternberg, Grigorenko, & Bundy, 2001). Based on my own clinical experience and conversations with other psychologists working in the field, there are numerous examples of people with FSIQ over 70 who have been accepted into service due to their clear need for specialist support, whilst many people with FSIQ's below 70 can appear to function perfectly well with little or no support from specialist services. Nevertheless, at this time the primacy of FSIQ as a diagnostic tool remains embodied in diagnostic criteria and service specifications. This reflects the predominantly medical based approach to understanding learning disability; it's assumed to be a distinct and separate category which can be diagnostically identified and labelled.

1.1.2 The Social Model of Disability

Learning Disability can also be understood from a social model of disability. The Social Model of Disability sees disabilities as being largely constructed through the workings of society; a wheelchair user is disabled not by their need to use a chair, but by a built environment which fails to accommodate the diverse accessibility needs of the large section of the population who are not fully ambulatory. This non accessible built environment is the

product of many years of societal attitudes in which it was acceptable to only think of the needs of the most able members of society when designing spaces.

From this perspective, people with LD have historically been separated from mainstream society. Until the late 1980's many people with LD were subjected to the same model of institutionalised care as were people with long term mental health difficulties (MENCAP, n.d.). The Department of Health 'Valuing People Now' strategy of the late 1980's marked a shift towards deinstitutionalisation and normalisation of people with Learning Disabilities which has now largely been completed. The large state hospitals of the preceding hundred years are now mostly closed with care being provided instead in a variety of different environments such as family homes, supported living and small group residential settings. In addition, many people with milder learning disabilities are able to live fully or partly independent lives in their own homes.

Historical attitudes to people with Learning Disabilities have marked them out as different and subnormal. In agrarian societies, limited intellectual functioning may not be a significant disadvantage, but from the industrial revolution onwards it became more of a disadvantage. This eventually led to Victorian era understandings of the undeserving poor through to the out of sight, out of mind institutionalised approaches of the early 20th century. Terms which historically had technical meanings in the LD world, such as Cretin or Moron (Drever, 1952) became terms of abuse in mainstream culture. Such attitudes of neglect and abuse are not gone, as incidents such as the recent Winterbourne View scandal (Department of Health, 2012) so clearly demonstrated. Even the terminology has been periodically changed, from mental retardation to learning difficulty and learning disability. Moves are afoot to use the

term intellectual disability in future though throughout this document I shall use 'learning disability'; presently the most accepted term in the UK.

Whilst the dominant model of understanding and defining learning disabilities remains a medical one, it can be seen that there are considerable difficulties with the diagnosis of learning disability. Further, understanding the history and exclusion experienced by people with learning disabilities leads one to view Learning Disability as largely socially constructed. As such, an epistemologically pluralist position, in which both perspectives offer value in understanding the issue, is the approach taken within this document. This seems consistent with the values of Counselling Psychology.

1.1.4 Epidemiology of Learning Disability

An epidemiological understanding of learning disability can only be offered from within a medical model approach as it requires an assumption that the condition can be defined and measured. If rates of learning disability adhered accurately to the classical normal distribution curve assumed by test manufacturers, and if defining and measuring rates of learning disability in a population was straightforward then we would expect a population prevalence rate of about 2% (based on a required FSIQ at least two standard deviations below the population mean). In the UK, lifetime prevalence rates of learning disability are estimated to be between 1% and 3% (Carr & O'Reilly 2007). Approximately 1.2 million people in the United Kingdom are believed to have mild or moderate learning disabilities (Great Britain, Department of Health 2001), defined as FSIQ between about 55 and 70 (Carr & O'Reilly 2007). Rates are likely to vary throughout the UK, as to some extent, performance on a cognitive assessment is related to education and opportunity. Rates are therefore likely

to be higher in areas of poor socio-economic development where high quality education and support networks may be less readily available.

1.2 Defining Anxiety

1.2.1 What is Anxiety

Anxiety is a common experience related to perceived threats to the self, consisting of a range of physiological processes and cognitive biases. All information in the following section is drawn from SK277 Human Biology, Book4: Life's Challenges (The Open University, 2004). Physiologically, anxiety is associated with increased activation of the hypothalamus-pituitary-adrenal (HPA) axis and the increased release of hormones including adrenalin and cortisol. The HPA axis and these hormones regulate the 'fright, fight or flight' response common among many animals, which is intended to maximise survival prospects (strictly, reproductive success) when under threat. As such, anxiety reactions are associated with changes in a number of body systems. Within the circulatory system, increases in heart rate and respiratory rate maximise the availability of oxygen to key muscle groups, changes in vasodilation and vasoconstriction maximise blood flow to major muscle groups whilst also minimising injury related losses in non-critical areas. Within the endocrine system, adrenalin and cortisol release is increased via the HPA axis, which has numerous effects throughout the body. Metabolically, increased release of energy in the form of glucose and fats into the blood stream and reduced activity in non-survival critical systems such as digestion and reproduction maximise energy availability to fight/ flight muscle groups. Endorphins are produced reducing perceived pain, the immune and digestive systems scale back their activity to preserve energy. Changes in perception and cognition also take place. Pupils

dilate to maximise light intake, our attentional systems become hyper attentive to threat stimuli and cognitive schemas associated with threat become activated.

The threat stimuli triggering this wave of activity may be externally situated in the outside world, or internally generated through cognitions and ruminations. Whilst this range of responses can be adaptive in the case of a short term threat, they can become maladaptive when the perceived threat becomes chronic. For instance, prolonged stress is associated with increased rates of heart disease and diabetes. Whilst anxiety can be described as a physiological and cognitive issue, these responses are only triggered once a threat has been perceived; anxiety can therefore be thought of as cognitively mediated. Anxiety which is short term and associated with specific and transient threats to the self is a normal human experience. However, anxiety which becomes enduring or disproportionate to the perceived threat on a regular basis can become an issue for which people might seek individual therapy and is therefore relevant to Counselling Psychology.

Anxiety can also be understood from a pluralistic perspective. In the context of this research, a pluralistic position is being adopted between a medical model approach to anxiety and a phenomenological/ experiential one.

A medical model approach to anxiety considers it to be a diagnostically dichotomous condition. It focusses on the nomothetic aspects of the experience and can be reductionist in the sense that attempts are made to reduce anxiety to a core set of measurable phenomena. In the case of The International Classification of Diseases, Version 10, anxiety disorders are defined as:

Disorders in which manifestation of anxiety is the major symptom and is not restricted to any particular environmental situation. Depressive and obsessional symptoms, and even some elements of phobic anxiety, may also be present, provided that they are clearly secondary or less severe.

From such a definition, anxiety is seen as measureable and dimensionable. The model assumes that human experience can be categorised and measured (Laing, 1971) and is connected with diagnostic checklists such as the Beck Anxiety Index (Prout & Schaefer, 1985) and Glasgow Anxiety Scales (Mindham & Espie, 2003) etc. Such measures help to create a dichotomous approach to diagnosis in that they will report a diagnostic cut-off score above which a diagnosis of anxiety can be given. If a respondent becomes less anxious, their score will fall. If it falls below the diagnostic cut-off then they will no longer be diagnosed as suffering from anxiety. Such measures acquire their validity by showing that they correlate well with other similar measures and with theoretical constructs of anxiety. Medical model research is biased towards larger scale quantitative research, with gold standard research consisting of designs such as randomised control trials and meta-analytic studies such as Cochrane reviews (The Cochrane Collaboration, 2013).

From a phenomenological or experiential perspective, anxiety is viewed as an idiographic, unique experience for each affected individual. This approach is more closely associated with the clinical skill of formulation (Johnstone & Dallos, 2006). Idiographic research methods are more likely to include qualitative and case study methodologies.

The medical and phenomenological approaches to understanding anxiety appear able to offer a pluralistic understanding of anxiety when considered together on their individual merits.

1.2.2 Epidemiology of Anxiety

An epidemiological approach to anxiety attempts to understand the prevalence rates and distribution of the condition. This is therefore an approach which relies on being able to measure whether large numbers of individuals within a given population meet diagnostic criteria and as such adopts a medical model approach to diagnosis and measurement.

Epidemiological studies can adopt a number of approaches to attempting to measure the incidence rate in a population such as attempting to carry out new measurements (Smiley, et al., 2007), or relying on pre-existing data (Michael, Zetsche, & Margraf, 2007). In either event, two key challenges for any study will be to understand what the diagnostic approach taken is actually measuring and to what extent does the sample obtained reflect the incidence rate that might be present in the target population? Notwithstanding these issues, epidemiological studies can provide a useful framework for understanding how frequently a cluster of symptoms may occur in a given population.

Numerous papers have been published examining the epidemiology of anxiety in various populations and using various measurement approaches. Michael, Zetsche & Margraf (2007) report a review of primary studies of anxiety across numerous western populations. They report lifetime prevalence rates (has the individual met diagnostic criteria at any point in their life) ranging from 13.6% to 28.8%. The authors suggest the wide range may reflect differences in case definition, diagnostic instruments, response rates, sample composition and different inclusion criteria for various anxiety disorders. Whilst these factors may all have impacted on reported rates, there is an implied understanding within this statement that anxiety disorders exist in different western populations at broadly similar rates. Kessler et al. (2012) report similar studies but highlight the apparently higher rates of anxiety

disorders found in the USA compared to Western Europe. Studies have been conducted in non-western cultures. Tanios et al. (2009) report studies conducted in the Arab world with wide ranging results often much higher than the generally reported figures earlier, though these tended to be in specific 'at risk' populations.

Michael, Zetsche & Margraf (2007) report twelve month prevalence rates for anxiety disorders ranging from 2.7% in China to 18.1% in the USA. In the United Kingdom, the Adult Psychiatric Morbidity in England survey (The NHS Information Centre for health and social care, 2009) reviewed the occurrence of common mental health disorders in adults in England. It reports the results of a survey of adults living in private households across England. It reports a point prevalence rate (symptoms within the last seven days) for mixed anxiety and depression of 9.0% for all adults and 4.4% for Generalised Anxiety Disorder.

Finally, Michael, Zetsche & Margraf (2007) also report age of onset (80-90% of cases manifest before age 35) and comorbidity (odds ratios of 6.6 for pairwise comparisons between an affective disorder and an anxiety disorder in the USA).

1.3 Anxiety in People with Learning Disabilities

1.3.1 Diagnostic Issues

Specific questions arise regarding diagnosis of anxiety in people with learning disabilities.

Dagnan & Lindsay (2004) describe three subsets of measures used with people with learning disabilities:

- General population measures which are used without adaptation, i.e. Beck's Anxiety and Depression Indices (Beck, Epstein, Brown, & Steer, 1988; Beck, Steer, Ball, & Ranieri, 1996)
- General population measures that are subsequently adapted for use with people with learning disabilities, i.e. the Brief Symptom Inventory (Derogatis & Melisaratos, 1983)
- Measures developed specifically for the Learning Disability population such as Glasgow Anxiety and Depression Scales (Mindham & Espie, 2003), (Cuthill, Espie, & Cooper, 2003)

The third group of measures may be the ones most likely to take into account the cognitive abilities of the population and will also have been validated against samples of people with learning disabilities. However, there are comparatively few of these measures available and they have only tended to be developed in recent years, so have not been used in the majority of surveys undertaken so far. Whilst these measures may also have been standardised against equivalent general population measures within the LD standardisation samples, their use does limit the ability to directly compare rates obtained from general population samples with those obtained from LD population samples.

There are also issues with the use of self-report measures with this population. This will be discussed in more detail later, but for now it's worth noting that the use of such measures with people with learning disabilities is open to challenge.

1.3.2 Epidemiology

Cooper et al. (2007) report incidence rates for a large scale assessment of mental ill health conducted in the catchment area of the Greater Glasgow Health Board in 2002-2004. From a

sample of 1023 adults, 552 (54.0%) were identified as possibly having a mental health issue. For people with mild learning disabilities, the overall point prevalence rate for anxiety disorders (excluding specific phobias) was 6.0%. They also reported overall rates for multiple diagnoses, 9.2% had two diagnoses, 2.4% had three, and 0.2% had four diagnoses.

The authors also list a number of risk factors; severity of learning disability, having experienced a higher number of life events in the last 12 months, being a smoker, living with paid carer support, severe physical disabilities, urinary incontinence and gender (females more likely to have mental health problems – odds ratio 1.333 (ibid.)). They also identified a number of factors which predict mental ill-health in the general population which do not appear to be predictive in the LD population; living in deprived areas, lack of daytime occupation, marital status and epilepsy. Dagnan (2008) argues that lifelong exposure to stigmatising and devaluing conditions makes people with learning disabilities more likely to perceive themselves negatively and to have low personal expectations. Such cognitive predispositions may predispose people to low mood and being less able to manage stressful situations, leading to higher rates of poor mental health.

Cooper et al. (2007) discuss issues of diagnosis amongst people with LD, highlighting that higher rates of mental ill health were found in their sample when using trained clinical judgement to diagnose instead of when using the diagnostic criteria described in ICD-10-TR or DSM-IV-TR. Mental ill-health of any type was diagnosed in 40.9% of the overall sample by clinical diagnosis, but only 16.6% using ICD-10 classifications and 15.7% using DSM-IV-TR classifications. The authors argue that systems such as ICD-10 and DSM-IV-TR do not take into account the impact of learning disability on mental health and that rates may be under reported using these systems.

1.4 What is Self-Compassion?

Self-compassion can be conceptualised from several different positions. A pluralistic approach accepts that each of these positions may offer a valuable perspective. Whilst compassion is a core facet of many belief systems, its presence in modern therapeutic approaches emerges from a predominantly Buddhist perspective. The Dalai Lama defines compassion as:

‘a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it’ (Gilbert, 2010a, p. 3).

Compassion focussed inwards on the self (self-compassion) can therefore be understood as sensitivity to the suffering of the self, with a deep commitment to try to relieve it.

Key researchers in the field have developed their own definitions of self-compassion. Gilbert describes self-compassion as the soothing component of a triad of emotion regulation systems alongside drive and threat based systems (Gilbert, 2010b). This is discussed in more detail in chapter 2. Gilbert notes that his understanding of compassion emerges from his clinical work and a hypothesised evolutionary role of self-compassion in humans. Gilbert offers clinical tools to help explore an individual’s sense of self compassion in therapy, but his definition has not been converted into a measure.

Kristin Neff defines compassion as consisting of three dyadic pairs of subcomponents of overall self-compassion. These dyads are:

- Self-kindness vs self-judgement
- Common humanity vs isolation
- Mindfulness vs Over identification

These dyads are incorporated in Neffs' Self Compassion Scale (Neff, 2003) discussed in more detail later. Development of these dyads emerged from Neff's attempts to construct a standardised measure of self-compassion. They are products of statistical analysis of large undergraduate student data rather than work with clinical populations or direct engagement with Buddhist teaching.

These three definitions have emerged from very different approaches to understanding self-compassion. A pluralistic understanding may see each of these approaches as offering a unique perspective on what self-compassion might be, without attempting to say that any one perspective can be more 'right' than any other.

1.5 Personal Reflections

No researcher can truly claim to be approaching their work without pre-existing biases, and I certainly don't claim to be doing that with this research. Having worked with people with learning disabilities for several years, I am an advocate for them to have their voices heard and to be recognised as equal members of society - something which happens all too rarely at present. Counselling psychology in the UK is presently debating its position with regards to social justice (Cutts, 2013; Hore, 2013; Ropani, 2013). At least as far as people with learning disabilities are concerned, I know where I stand on that issue.

Fellow psychologists who do not have day to day contact with people with learning disabilities have questioned the extent to which they might be able to contribute meaningful qualitative data to a study such as this. Whilst I discuss the evidence for their ability to do so later, at this moment I want to make the point that I strongly believe in the rights of people with learning disabilities to have their voices heard and respected. I fully appreciate that they

might find it more difficult than others to express those views, however I fail to see any reasonable argument for not giving them the same opportunities to express themselves that most other members of society take for granted.

I also have pre-existing views regarding Compassion Focussed Therapy. As someone with a long term interest in Buddhist philosophy and who uses aspects of mindfulness and CFT in my own clinical practice, I am expecting to see positive outcomes for the participants taking part in this study. However, my clinical training has taught me to look for the similarities across different models of therapy, and to believe strongly in the value of humanistic and psychodynamic understandings of what takes place during therapy. As a result, I am open to the idea that participants may show improvements in their experience of anxiety for numerous reasons, only some of which are directly related to the chosen interventional methodology. Shedler (2010) argues that even when therapists state they are conducting cognitive behavioural therapy, the most successful therapists are conforming closely to the principles of psychodynamic therapy.

Awareness of these views is the first step to being able to bracket them off. However, it would be naïve to assume that I am able to isolate myself from these views, or maybe even that I should try to do so. Assuming so would deny the hermeneutic argument at the heart of Interpretative Phenomenological Analysis as well as the psychodynamic concepts of transference. In reality therefore, I am acknowledging these views in order to bracket them off as best I can, but also to be aware that these values and beliefs will underpin my thinking and analysis in relation to this study.

Chapter 2. Literature Review

2.1 Search Strategy

A literature search was conducted for papers related to self compassion, psychological functioning and compassion focussed therapy. Two key resources used in this search were the online literature lists maintained on the Compassionate Mind Foundation website (The Compassionate Mind Foundation, 2013) and Kristin Neff's website (Neff K. , 2013). The majority of CFT papers were located through these lists.

In addition, online literature searches were conducted using the PsycINFO, Sciencedirect, EBSCO Academic Search Complete and EBSCO CINAHL databases as well as a Google Scholar Search. Google Scholar located most papers. The search terms used were:

(COMPASSION or CFT) and (ANXIETY or GAD)

Results were limited to papers from 1990 onwards, only english language papers were considered. 2220 papers were located, which were then sorted by order of relevance. The first 900 were reviewed, ceasing after 50 consecutive papers were deemed not relevant. Reference lists of all relevant papers were reviewed and alerts for relevant papers were created on Google Scholar and the University of East London Library electronic search tool. The search was last updated in March 2015.

2.2 What is Self-Compassion

2.2.1 The Construct and its Correlates

The two key psychologists currently researching self-compassion are Dr. Kristin Neff & Professor Paul Gilbert. Gilbert conceptualises how developing self-compassion might support a rebalancing of affect regulation systems in clinical work (discussed in detail in section 2.3). Dr. Neff explores self-compassion as a positive psychology construct, mostly through the development and use of the Self Compassion Scale (SCS), which is described in more detail in Chapter 4, Methodology. Neff conceptualises self-compassion from a Theravadan Buddhist perspective as consisting of three dimensional constructs (Neff K. D., 2003, p. 224):

- 1) Extending kindness and understanding to oneself rather than harsh self-criticism and judgement.
- 2) Seeing one's experiences as part of the larger human experience rather than as separating and isolating
- 3) Holding one's painful thoughts and feelings in balanced awareness rather than over-identifying them.

This research takes place within a positivist paradigm. It is concerned with developing an understanding of the psychological concept of self-compassion through mostly correlational studies comparing it to other established positive psychology concepts such as self-esteem, or exploring the extent to which it can explain variance in correlated factors such as self-worth. With some exceptions, the majority of studies use undergraduate student samples, in Neff's case drawn from a large Midwestern university educational psychology course and as

such, questions must be asked about the ability to generalise to broader populations from these studies. Methodologies are based on the statistical analysis of results from established self-report measures and are correlational in nature so no cause-effect links can be inferred from the majority of the studies. It is possible to question the validity of self-report measures of self-esteem. Self-compassion may not be a construct which can be reduced to simple measurement, and even if it is, there may be no guarantee that people will have sufficient insight into their level of self-compassion or that they will be evaluating their experience relative to the same reference group (Neff, Pisitsungkagarn, & Hsieh, 2008). Finally, with few exceptions, all studies are cross sectional in design and therefore unable to evaluate whether or how changes in self-compassion might impact on the correlated constructs.

The main comparison construct is self-esteem. They are generally shown to be poorly to moderately correlated (Neff, Rude, & Kirkpatrick, 2007a; Neff, Kirkpatrick, & Rude, 2007b; Barnard & Curry, 2011) or described as overlapping but distinctive constructs (Neff & Vonk, 2009). In Neff & Vonk (2009), the authors argue that self-esteem may be available to people when things are going well, but that self-compassion may be more reliably available when things go wrong. For example, Allen, Goldwasser and Leary (2011) found that increased self-compassion is linked to a greater willingness amongst older adults to accept adaptive technology as well as greater perceived wellbeing amongst those older adults who felt they had poor physical health. Self-esteem has been criticised as being at risk of promoting narcissism and ego-defensive strategies, an accusation which does not appear to apply to self-compassion for which there was found to be almost no association (Neff & Vonk, 2009). Kwan & Kuang (2009) have explored self-compassion and self-esteem cross culturally in US

(n=89 female) and Chinese (n=72 female) undergraduate students. They found that levels of self-compassion were higher in Chinese students, whilst self-esteem was higher in US students.

Neff & Vonk's paper reports two studies, the first (n=2187 recruited through newspaper adverts) and the second (n=165, university undergraduate students). They found that self-compassion has a stronger negative association with ego focussed reactivity than self-esteem and that it predicted additional variance in the negative direction for numerous sub components including self-worth instability & contingency, social comparison, self-rumination, anger and need for cognitive closure. They also found it predicted additional significant variance after accounting for self-esteem in happiness, optimism and positive affect, as did Neff, Rude & Kirkpatrick (2007a).

Akin (2012) examined self-compassion and automatic thoughts in 299 Turkish undergraduates. This was a cross-sectional study examining links between self-reported self-compassion (using the SCS) and automatic thoughts associated with depression (using the Automatic Thoughts Questionnaire (Hollon & Kendall, 1980 in *ibid.*). Their model fit the data extremely well ($\chi^2 = 0.05$, $p = .03832$) and overall accounted for 39% of the variance in automatic thoughts. It showed that automatic thoughts related to depression were negatively predicted by self-kindness, common humanity and mindfulness ($\beta = -.16$, $\beta = -.13$, $\beta = -.20$ respectively) and positively predicted by self-judgement and over-identification ($\beta = .30$, $\beta = .27$ respectively).

Akin argues that self-compassionate people may be thought of as being positively psychologically adjusted, whereas those who are low in self-compassion might be viewed as more psychologically maladjusted. Akin (2014) further reports that self-compassion

explained 56% of the variance in psychological vulnerability (using the Self-Compassion Scale and Psychological Vulnerability Scale) amongst 281 Turkish university students. Akin's studies may however be limited by their correlational design and non-clinical undergraduate sample.

Findings regarding positive affect are also reported by Leary et al. (2007) in Barnard and Curry (2011) who report decreased self-compassion being associated with increased negative affect (see also Neff, et al., 2007b and Tate et al., 2007) and decreased positive affect. Self-compassion was also associated with degree of emotional exhaustion.

Neff, Kirkpatrick & Rude (2007a) examined the relationship between self-compassion and positive psychological health. In a study using 91 undergraduates in a lab based mock job interview, using self-report measures and textual analysis they found that self-compassion but not self-esteem negatively correlated with anxiety. In study two, using a Gestalt two chair exercise they demonstrate positive change in levels of self-compassion between two time points. In a separate paper the same authors explore links between self-compassion, positive functioning and the big five model of personality (Neff, Kirkpatrick, & Rude, 2007b). In a study of 177 undergraduate psychology students they found a significant positive correlation with self-reported measures including wisdom, personal initiative, curiosity and exploration, agreeableness, extraversion and conscientiousness. They also found a significant negative correlation with neuroticism. Finally, Neff (2008) found links between self-compassion, self-construal and life satisfaction, although within cultures they did not find any connection with religious belief.

Links with wellbeing were also explored by Hollis-Walker and Colosimo (2011) in a study of 123 Canadian non-meditating undergraduate and community participants. They describe self-compassion as a partial mediator of the mindfulness-happiness relationship.

Byer, Lykins and Peters (2012) found that across meditators and non-meditators, mindfulness and self-compassion accounted for a significant variance in wellbeing. Similar results were found in a non-meditating undergraduate sample (n=203) wherein self-compassion accounted for a significant amount of variance in wellbeing.

Self-compassion has also been examined in connection with age using cross sectional designs (Werner, et al., 2012). Broadly, in healthy controls, self-compassion as reported by completion of the SCS, appears to increase with age, whereas in people with a diagnosis of social anxiety disorder, it decreases with age.

Most research has taken place within western cultures; however self-compassion has been examined cross culturally. In 2008, Neff examined self-compassion between US (n=181), Thai (n=223) and Taiwanese (n=164) university undergraduate students to explore assumed east-west cultural differences in levels of self-compassion. Whilst acknowledging the difficulties of translating concepts and measures cross culturally, they found the highest levels of self-compassion amongst Thai students, lowest amongst Taiwanese and mid-levels amongst US students. They highlight greater independence in US and Taiwanese culture compared to greater levels of interdependence in Thai culture. They suggest that differences in self-compassion may need to be understood as the result of specific cultural factors rather than a generalised east-west dichotomy.

Overall, Neff and others appear to have established an initial evidence base which suggests that self-compassion is separate from constructs such as self-esteem. It appears to be positively correlated with a range of psychological constructs and characteristics which may be associated with positive mental health. However, the work of Neff in particular as well as Akin and others can be criticised for its reliance on undergraduate student populations. The potential for findings from these samples to be generalised to the wider population, and in particular to mental health populations must be considered with care. Henrich, Heine and Norenzayan (2010) argue that US undergraduates represent an outlying population on many measures of psychological functioning and that generalising findings from these samples to the wider population may be particularly unsuitable. Most notable for this thesis is the observation that American subjects in general tend to disproportionately prize individualism and choice compared to many other cultures. Additionally, since the samples are drawn from university undergraduates, they may often be younger than the general population norm and better educated than most. When thinking of mental health issues in undergraduate student populations, Stallman (2010) highlights that incidence rates of DSM-IV anxiety mood disorders may be significantly higher in these populations (19.2% of 6479 undergraduates from two large Australian universities) compared to the population norm (3% (Australian Bureau of Statistics, 2008 in Stallman 2010)).

Bearing these factors in mind, Neff's work as well as Akin's and that of several other authors mentioned in this thesis must be considered with care. In the absence of confirming evidence from other population groups, the arguments against generalising from these particular samples may seem to represent a significant challenge to the validity of these strands of research.

2.3 Paul Gilbert and Compassion Focussed Therapy

2.3.1 Paul Gilbert and the History of CFT

Paul Gilbert has developed Compassion Focussed Therapy over a period of twenty years as an intervention aimed at helping people who experience high levels of shame and self-criticism (Gilbert P. , 2010a). It developed from Gilbert's observation that people would often understand the logic of CBT, but not feel any different as a result (Gilbert P. , 2010b). Gilbert came to describe this as the 'heart-head lag' (Lee, 2005) as a way of reflecting the well described dual process model of cognition-emotion. Gilbert's observation was that such people often seemed to lack self-warmth and to feel a sense of disconnectedness from other people. From here, Gilbert focussed his therapeutic work on the client's emotional experience and on developing feelings of self-warmth, partly through focussing on a compassionate and warming therapeutic encounter. This is in contrast to classic Cognitive Behavioural Therapy which might be criticised for being overly focussed on cognitions at the expense of emotions (Wills & Sanders, 2013).

Over time this approach has developed into Compassion Focussed Therapy, combining ideas from several different domains including evolutionary psychology, cognitive psychology, cognitive behavioural therapy, attachment theory and Buddhism. Doing so involves integrating thinking from a range of epistemological positions including but not limited to the realist position of cognitive psychology and the somewhat more phenomenological evidence base of object relations and attachment theory. While Gilbert does not explicitly express an epistemological position for his work, he appears to subscribe to a pluralistic approach in which issues can be understood from multiple perspectives, with no one perspective able to offer a complete account of an issue. Going beyond this, CFT represents

both a theoretical and practical attempt to integrate these different positions into a methodology which is aimed at achieving positive outcomes for people in psychological distress. As such, Gilbert's position can be seen as strongly pragmatic.

2.3.2 What is the theory?

One strand to the theoretical foundations of CFT lies in evolutionary models (Gilbert 2007; Gilbert, 2010a; Gilbert 2010d) and our 'tricky brains' (Gilbert & Choden, 2013). Gilbert uses a model of mood and cognition which he divides into 'old brain' (predominantly related to emotions, behaviours and relationship-seeking) and 'new brain' (predominantly related to imagination, planning, rumination and reasoning) (Gilbert, 2010d). This model is based on evolutionary understandings of the development of the human brain, in particular the way that it can be thought of as containing structures which are recognisable as being similar to those in other animal species with whom we may once have shared common ancestors (Smith & Stevens, 2002; Gilbert, 2006). Gilbert uses this model to address issues of rumination, shame and over-identification by highlighting that whilst our 'old brains' control many of our emotional and behavioural responses, we do not get to choose the way that our brains operate. In fact they are the result of millions of years of evolution and are optimised to maximise our chances of reproductive success in a very different environment to the one we find ourselves in now (the Savannah Hypothesis (ibid.)). As a result, it is hardly fair to feel responsible for all of our emotional and behavioural difficulties. It is however our responsibility to take what action we can to alleviate those difficulties. The evolutionary model therefore offers an understanding which may be used to both minimise feelings of excessive responsibility, shame and rumination whilst also promoting motivation to change.

Perhaps the major aspect of the theoretical framework of CFT is Gilbert's three factor model of emotional regulation. This is largely based on the neurobehavioural model of affiliative bonding offered by Depue and Morrone-Strupinsky (2005). Gilbert's model (described in more detail in sections 2.3.2.1 to 2.3.2.3) represents a considerable simplification of the original Depue and Morrone-Strupinsky conceptualisation of neurological functions associated with affiliative bonding. It also goes further in linking this system to complex aspects of human behaviour such as attachment (Gilbert 2010a).

The Depue and Morrone-Strupinsky model takes a number of important steps in understanding the complex mammalian social behaviour of affiliative bonding. Affiliative bonding is defined by Depue and Morrone-Strupinsky as enjoying and valuing close interpersonal bonds and being warm and affectionate (2005, p. 314). Their model steps away from neuroanatomical correlations with behaviour and instead offers an account based on the role of the neurotransmitters dopamine, μ -opiates and oxytocin, across multiple brain regions in both the appetitive and consumptive phases of bonding behaviour. The model also attempts to offer an explanation of individual differences in these behaviours. For example, by noting the possible role of μ -opiates in modulating individual differences in social closeness behaviours.

Gilbert bases his model of a soothing system largely on Depue and Morrone-Strupinsky's model. In doing so he makes a number of significant changes. Principally, he changes the model from one intended for consumption by the scientific community to one which may be understood by members of the general population who are experiencing psychological distress. This requires a dramatic simplification of the model to one in which, for instance,

the only significant neurotransmitter mentioned is oxytocin and where neuroanatomic links are removed completely. Additionally, the model is expanded from one focussed on the tightly defined behaviour of affiliative bonding (as described above) to one more closely aligned to conceptualisations of attachment (Bowlby, 1973).

Gilbert also draws, in part, on the Depue and Morrone-Strupinsky model and its analysis of the function of dopaminergic systems in the appetitive phase of behaviour to develop his conceptualisation of a drive system. Finally, with regards to the threat-response system he draws on separate research (Caspi and Moffitt, 2006) to offer a conceptualisation closely allied with neuroanatomical structures such as the amygdala and hypothalamus-pituitary-adrenal axis as well as the neurotransmitter serotonin.

These steps allow Gilbert to offer a three factor model of emotion regulation which may appear to be relatively simple to explain to clients. The model suggests that each emotion regulation subsystem is both neuro-chemically and neuro-anatomically separate from the others. However, Depue and Morrone-Strupinsky note that *'models of personality traits based on one neurotransmitter or neuropeptide, such as μ -opiates, are clearly too simplistic, and will require the addition of other modifying factors'* (2005, p. 349), suggesting that from a scientific perspective such models must be considered with caution.

Therefore, whilst these changes might make the Gilbert model more easily understandable and useable in a therapeutic environment, they may also significantly reduce the extent to which the model may be considered an approximation of underlying functional neurological

processes. They therefore appear to represent a shift away from greater scientific validity towards greater clinical utility.

However, moving on to consider the role of Gilbert's simplified model within CFT, the focus of attention is less on the nature and conceptualisation of the three emotional subsystems (drive, soothing and threat) and more on their dynamic interaction (figure 2.1).

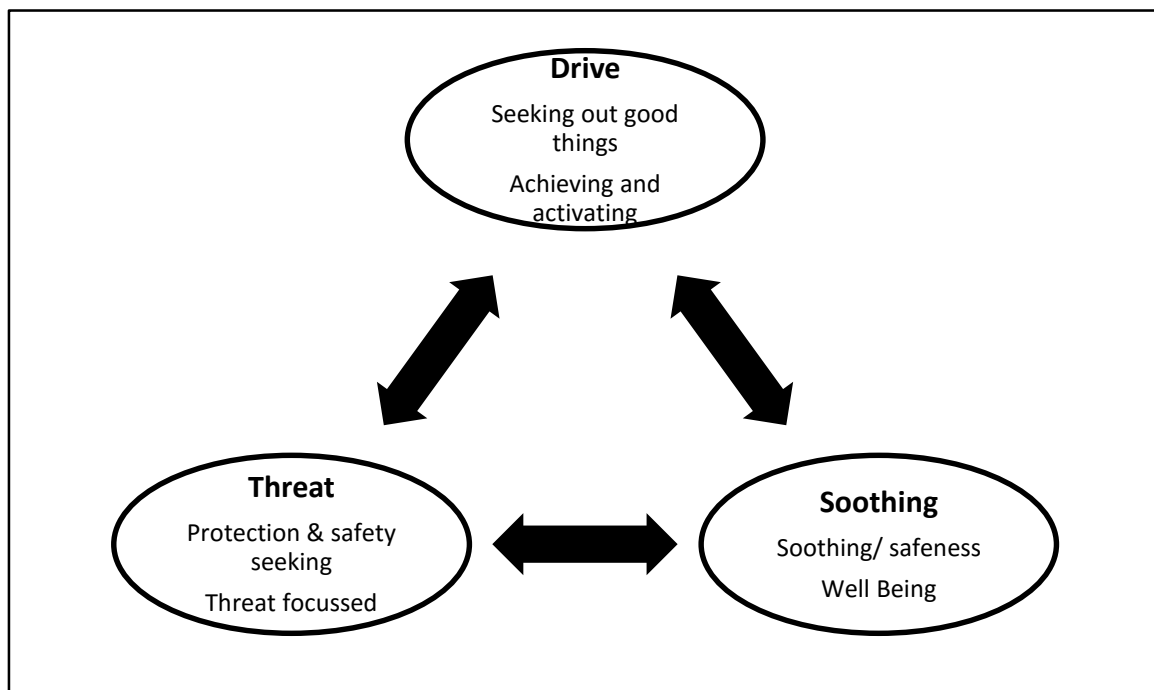


Figure 2.1. Three Interacting Emotional Subsystems (adapted from Gilbert 2010c).

Gilbert argues that much of our emotional experience derives from the dynamic interplay of these three subsystems (Gilbert P. , 2010a). For instance, we might experience uncertainty and worry if facing a dilemma between our drive and threat response systems when considering a high risk decision.

Figure 2.1 illustrates these three components as being of equal importance. The extent to which each component may have weight in an individual's life experience is partly a result of genetics and evolution, but also their life experiences. A child brought up in a high threat,

low soothing environment may have a more developed threat response system and a less developed soothing system as a result of their experiences (figure 2.2). The three systems operate in dynamic interplay, with the extent to which they are active being determined by a person's perceptions and cognitions; the threat system may be relatively more active in a perceived high risk environment than a low risk one.

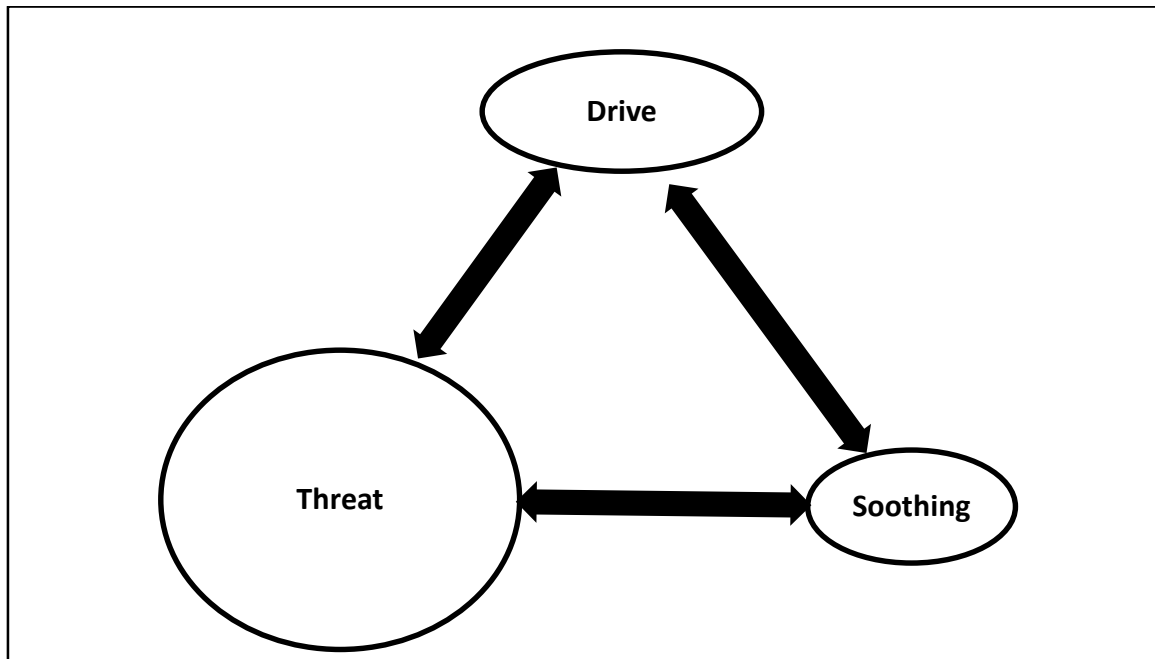


Figure2.2. High Threat/ Low Soothing Interacting Subsystems.

2.3.2.1 The Threat System

The threat system is closely allied with our stress response as described in Chapter 1. The function of our threat response system is to alert us to potential threats and either protect us or prepare us to deal with the threat. It is associated with emotions such as fear, disgust, anxiety and anger (Gilbert P. , 2010c). It has been powerfully selected for throughout our evolution and is now a major part of our emotional world. The system operates on a 'better safe than sorry' system (ibid.); it's more adaptive to over react to false alarms than to ignore a genuine threat to life. As a result our threat response systems can now be triggered by

genuine threats but also by potential or possible perceived threats. These real or perceived threats could be either threats to physical wellbeing or to social status and roles. They might be externally triggered or internally generated perceptions of threat (Gilbert P. , 2010a).

Classical cognitive behavioural therapy could be said to focus on down-regulating the threat regulation system by altering the client's perception of risk. For example, progressively exposing a client to a feared object (i.e. a spider) and inviting them to recognise that their perception of the risk posed by the object exceeds the objectively evaluated risk. Doing so may allow them to re-evaluate their perceptions and reduce the scale of their threat response when exposed to the feared stimuli in future.

CBT can also consider safety behaviours, the patterns of behaviour we adopt in order to avoid an unwanted negative consequence. Safety behaviours also form a core part of a CFT understanding of threat response. From a CFT perspective, safety behaviours represent strategies which are adopted for threat avoidance or self-protection purposes. However, many safety behaviours have unintended negative consequences. For example, a socially anxious client might avoid social encounters in order to avoid the threat of embarrassment caused by their perceived lack of success in such situations. However, avoiding social situations might also reinforce their sense of isolation and perception of themselves as someone with poor social skills. It may also reduce the potential for corrective experiences of positive social contacts.

2.3.2.2 The Soothing System

Gilbert describes the soothing system as a system whose aim is the achievement of contentment (2010a). He describes contentment as '*... a form of being happy with the way*

things are and feeling safe; not striving or wanting; an inner peacefulness that is a quite different positive feeling from the hyped-up, excitement or “striving and succeeding” feeling of the drive-excitement systems. It is also different from just low threat, which can be associated with boredom or a kind of emptiness’ (2010a, p. 48). The neurotransmitter Oxytocin and its associated neurological systems are closely associated with feelings of affiliation, trust and feeling soothed and calmed in interpersonal relationships. Along with the opiates, oxytocin is closely associated with this system (Carter, 1998; Depue & Morron-Strupinsky, 2005, Uvans-Morberg, 1998, Wang, 2005 all in Gilbert, 2010b; Gumley, Braehler, & MacBeth, 2014).

In a substantial paper, Depue & Morron-Strupinsky (2005) link this system to the development of attachment behaviour (Bowlby, 1973). The paper takes a detailed approach to examining the neurobiological evidence linked to ‘affiliative bonding’ and then linking this to attachment. Gilbert builds on this paper and describes the soothing system as emerging from *‘social, developmental, evolutionary and Buddhist psychology; and neuroscience’* (Gilbert P. , 2009). He links these perspectives together through the term ‘social mentalities’ and describes attachment as the social mentality of caregiving and care eliciting/receiving.

By contrast, Buddhist theory aims to develop a state of non-attachment in which security is not dependant on representations of objects or relationships, since all things change in the real world leading to continual tension between reality and representation. This appears to contradict the idealised state described in attachment theory where security is derived from positive internal representations of relationships. Sahdra & Shaver (2013) argue that both approaches might be attempting to describe an optimal state of balance between

individualism and social relationships, but do so from differing cultural backgrounds (individualist western vs collectivist eastern).

Gilbert mainly writes from within a cognitive neuroscience/ evolutionary paradigm. It is in his integrative understanding of attachment and the soothing system and his development of social mentalities that his pragmatic approach to integration can be most clearly seen. How successfully he has done so, perhaps particularly with regards to the incorporation of Buddhist non-attachment remains to be seen.

2.3.2.3 The Drive System

The drive system is also described as the '*incentive and resource-seeking, drive-excitement system*' (Gilbert P. , 2010a). It is intended to produce positive feelings which motivate us to seek out resources that may help us to achieve goals. It is closely associated with the neurotransmitter Dopamine. Impaired regulation of this system may be associated with both hypo- and hyper-manic states (ibid.).

If the drive system is thwarted then the threat system may become activated. Equally, the drive system may be over developed in some people as a compensatory strategy to address shortfalls in managing their threat system caused by an underdeveloped soothing system.

2.3.3 How does Compassion Focussed Therapy work?

Gilbert describes CFT as an integrative therapy (Gilbert P. , 2009), although it can be aligned with third wave cognitive behavioural therapies (Gilbert P. , 2010b). Many of the interventions may feel familiar to someone trained in these methodologies (mindfulness, thought records etc.). Whereas most therapeutic interventions focus on down-regulation of the threat system, the overall goal of CFT is a rebalancing of the three affect regulation

systems (drive/ soothing/ threat). This may mean identifying and 'toning up' the soothing system, achieved through a focus on developing compassion and self-compassion.

Gilbert describes five key steps to a CFT intervention (2010a):

1. Accept feelings for what they are rather than avoiding them or allowing them to become intolerable, overwhelming or frightening
2. Use an evolutionary formulation of the reasons these feelings exist: they arise in part because of how our brains have evolved. That's not our fault, but we can learn to take responsibility for regulating our feelings.
3. Learn to be compassionate and understanding to ourselves, depersonalise and de-shame ('I'm not the only one'), and switch to a compassion focus if threatened.
4. Recognise unhelpful self-criticism and refocus on self-compassion when becoming aware that self-criticism has been activated
5. Recognise unhelpful rumination and replace it with helpful compassion focussing and practice.

Step 1 involves practicing compassionately accepting feelings throughout therapy. It reflects one aspect of the range of skills and attributes Gilbert associates with compassion, illustrated as the compassionate circle (figure 2.3).

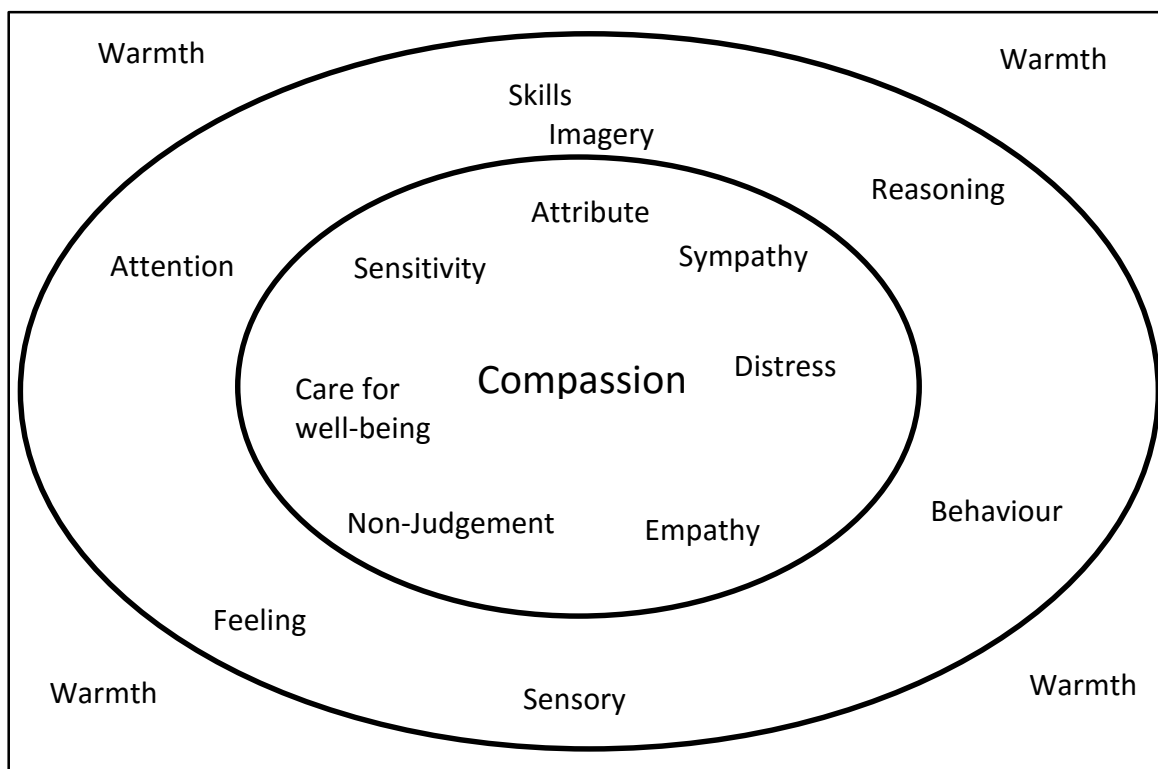


Figure 2.3. The Compassionate Circle.

Gilbert describes the circles as representing qualities which are already part of our compassionate selves, but which may require work to tone up. All such work should be conducted within an approach based on warmth, both by the therapist and also in time by the client. Gilbert (2010b) describes the inner circle as the 'what's' of compassion and the outer circle as the 'how to's' for the inner circle. Specific interventions are focussed on the development of the outer circle attributes to boost the inner circle ones.

Step 2 focusses on psycho education and shared development of a formulation which puts at its heart an evolutionary understanding of our minds. It also encompasses an explanation of Gilbert's idea of social mentalities, which attempt to describe the range of neural processes and biases that come together to optimise our thinking in any particular mood state. In CFT, social mentalities describe the multiple changes in aspects of cognitive processing which take place when either feeling threatened or compassionate (figure 2.4).

So in effect, social mentalities state that we conduct the same processing tasks in each mental state, but that the nature of the processing that takes place within those tasks changes substantially between social mentalities.

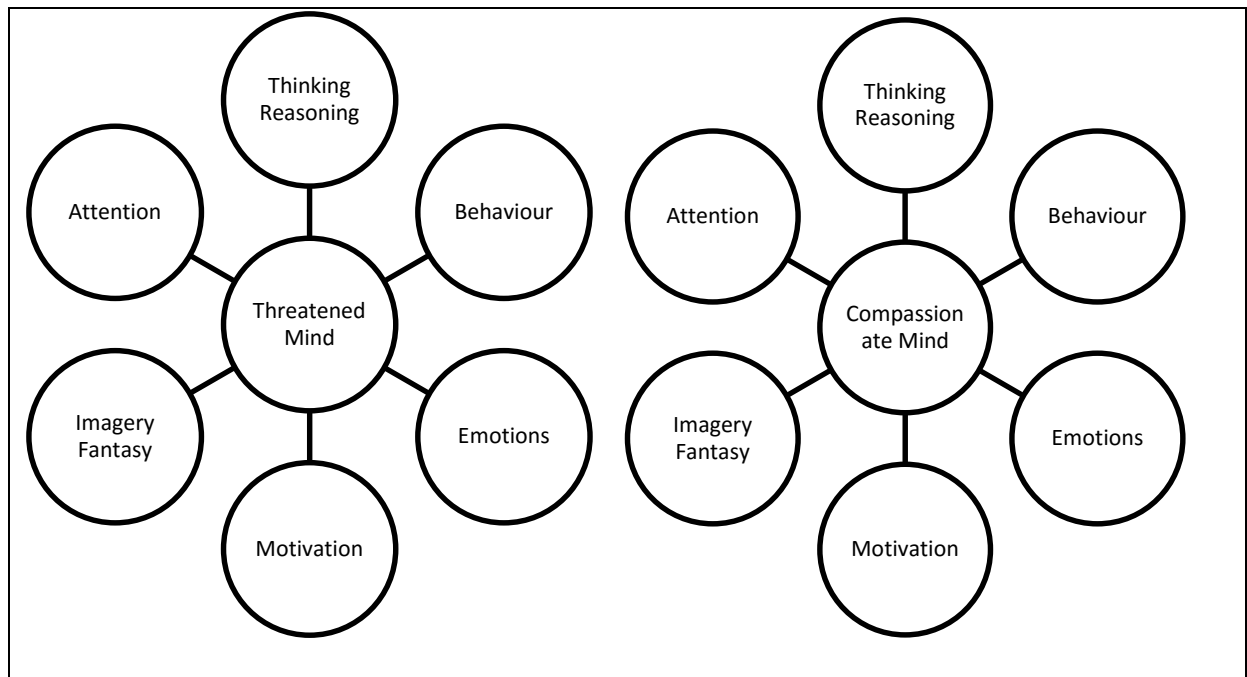


Figure 2.4. Social Mentalities - Threatened vs Compassionate Mind (adapted from Gilbert 2010a).

Imagery is a major component of CFT, most closely associated with step 3. In a study of 197 undergraduate students, Gilbert et al. (2006) developed a model of depression strongly linked to trait self-criticism. In this model, it is the relative availability of self-critical versus self-reassuring imagery which moderates self-criticism and therefore depression. Gilbert et al. argue that this model indicates that a key therapeutic focus should be on developing self-reassuring imagery since it appears that the availability of such images is more important than their quality in mediating symptoms. They also argue that therapy should be focussed on developing internal scripts based on warmth, compassion and forgiveness.

After an initial acclimatisation to mindfulness of breath, Gilbert (2010a) argues that compassionate meditations can be oriented in four main ways:

1. Developing the inner compassionate self by creating a sense of becoming a compassionate person in the same way an actor imagines themselves becoming the character.
2. Compassion flowing out from you to others.
3. Compassion flowing into you from others.
4. Compassion directed towards yourself. For many people this can be the hardest element.

Jazaeri et al. (2013) showed in a study of 100 adults that the amount of formal meditation practiced during a 9-week programme was associated with increased compassion for others.

Items 4 and 5 rely on homework and guided discussion of issues arising between and during sessions. Homework sheets, much like CBT homework sheets, ask clients to reflect on incidents between sessions which have triggered self-critical thinking. However, in CFT, the focus is on identifying threat enhancing cognitive distortions and developing self-compassionate alternative thoughts.

In summary, Gilbert (2010a) describes the mechanisms of change in CFT as:

1. Disengagement from (inner) stimulators of threat (rumination, worry etc.) and refocus on compassionate insights, thoughts, feelings and behaviours.
2. Developing compassionate detachment from the 'inner storms' of emotion.
3. Stimulating the soothing system by developing compassionate refocusing and imagery.
4. Developing the ability to engage with aversive inner experiences such as trauma memory or avoided emotions by developing an inner compassionate base.

Lo (2014) developed a customised eight week self-compassion based group intervention. Whilst reporting positive results, he notes three specific problems related to teaching self-compassion. Firstly, compassion practices can induce vulnerability and strong negative emotions, such as avoidance or fear reactions. Secondly, participants may express doubt and uncertainty about the purpose and intention of practicing compassion. People who have not experienced compassion may report 'blankness' during practice. Thirdly, compassion practice may be associated with relational issues, potentially causing participants difficulty sharing their practice with partners and family.

To address these issues, Lo recommends firstly bringing to mind the purpose of practice. Secondly, developing a mindful persistence in exploring the balance point where the difficult experience of practice moves from being difficult but tolerable to intolerable. Thirdly, the use of reflective writing and homework records.

2.4 CFT for Specific Mental Health Conditions

Two review papers have now been published summarising key findings in regarding CFT (Beaumont & Hollins Martin, 2015), (Leaviss & Uttley, 2015). Both reviews identify the potential of CFT but note that the quality of studies published to date is relatively poor.

2.4.1 Anxiety

Welford (2010) extends CFT to the treatment of anxiety disorders and cites consolidated case histories, arguing as does Gilbert that anxiety occurs not just as a consequence of processes in the threat response system, but also in other systems such as the soothing system. They suggest this may be particularly true in individuals with poor attachment histories.

There is little difference between Gilbert's approach to depression and Welford's approach to anxiety. Most of the theory, formulation and interventions are similar across both approaches, perhaps reflecting their shared understanding of problems as a result of brains which have developed in environments we did not choose and for which they are not optimised, combined with an appreciation of attachment and the three system understanding of emotion regulation. Anxiety is seen as a product of the threat system and its 'better safe than sorry' processing bias. CFT takes a less blaming approach to understanding the development and function of strategies such as self-monitoring and self-blame, seeing them as understandable safety strategies rather than cognitive distortions.

Welford argues that CFT is well placed to deal with an increasingly complex emerging understanding of the interplay between cognition and emotion with regards to general cognitive neuroscience and particularly anxiety (ibid.). Welford's argument is that CFT is well suited to cases of anxiety and in particular those where the client experiences high levels of shame or self-criticism, has insecure attachment or experiences 'heart-head lag' - they can understand the logic of interventions but do not feel any different as a result.

Turning to the research evidence, Boersma, Hakanson, Salomonsson & Johansson (2014) report a replicated single case study design with six participants. Their sample was non-clinical undergraduate students with self-reported social anxiety but no significant clinical presentation. Using a replicated design with a three week baseline, eight to nine week intervention and two to four week follow-up, they monitored social phobia, self-compassion (using Neff's SCS) and depression. Statistical analysis was mostly descriptive though they also used the Reliable Change Index (Jacobsen & Truax, 1991) (see section 3.11.2.1). They report that CFT was effective for three participants, probably effective for one and

questionably effective for two. Whilst this is only a small scale study it does provide some pilot evidence for the use of CFT with people with mild social anxiety. This paper's case study approach measuring anxiety, self-compassion and using reliable change index calculations to measure change are quite similar to aspects of this study.

Werner et al. (2012) examined self-compassion and social anxiety disorder (SAD) in 72 people with a principal diagnosis of SAD, as well as 40 healthy controls. Measures used covered self-compassion, social anxiety, fear of evaluation, depression and anxiety. They found lower levels of self-compassion in individuals with SAD. Specifically, individuals with a clinical diagnosis of SAD had lower overall levels of self-compassion, and reported lower scores on all six subscales of the Self-Compassion Scale. However, two scales which measure social anxiety in a variety of social situations did not produce any correlation between total level of self-compassion and level of social anxiety. It's unclear whether this might reflect a dichotomy in social anxiety and self-compassion or a measurement issue.

Although limited by the cross sectional nature of the study, the authors argue that interventions aimed at enhancing self-compassion might be of value for people with SAD. They argue that self-compassion might be low initially and then degrade over time within this population. They speculate that in people with SAD, self-compassion may have a buffering effect against negative cognitive biases and excessive self-criticism.

Adopting an IPA approach, Pauley and McPherson's (2010) paper explores the experience and meaning of compassion and self-compassion for individuals with depression or anxiety. It draws on interviews with ten participants, all white British (nine women, one man), drawn from the researchers' own clinical caseloads. It's unclear whether participants were on waiting list, receiving other treatment, or CFT when interviewed. Six participants had a

diagnosis of major depressive disorder, four specific phobia. Three participants also had a diagnosis of generalised anxiety disorder (GAD).

Interview questions drew on Neff's conceptualisation of self-compassion. Three superordinate themes were identified; Features, Utility and Difficulty of Self Compassion. Two subordinate themes were identified under each superordinate theme.

Participants reported drawing on their experiences of being compassionate towards others rather than themselves when responding and no participant spontaneously discussed self-compassion. The paper aimed to explore self-self and self-other compassion but when responding participants appeared to focus solely on self-other compassion, perhaps reflecting Gilbert's argument that for many people, thinking compassionately about themselves does not come naturally.

Participants linked compassion with kindness and forgiveness, and noted that compassion requires action. Participants acknowledged the value of self-compassion, but felt their own negative attitudes to themselves would be too long-standing to change. This may both endorse the face validity of self-compassion development and highlight the potential difficulty of persuading clients to engage in such work. The authors note the apparent causative link in participant narratives, suggesting that psychological distress leads to low self-compassion. By comparison, Gilbert argues that low self-esteem may be a risk factor for psychological distress.

Finally, Gilbert and Proctor (2006) report a study of a group CFT intervention aimed at people who had difficulties with shame, self-criticism and self-devaluation which was run in a day centre for people with mental health difficulties. Nine participants commenced the

programme, six completed. All participants reported reduced anxiety and depression, in all cases no longer meeting diagnostic thresholds post-intervention.

2.4.3 Depression

Two studies have explored the relationship between self-compassion, self-help interventions and depression in western populations. Shapira and Mongrain (2010) conducted a randomised control trial in Canada with three arms – (1) Self-compassion (n=63), (2) Optimism (n=55), (3) Control (n=70), recruited online via Facebook advertisements. Participants in both active conditions were less depressed at three months and happier up to 6 months compared to control. The authors argue that their study shows the value of easily accessible self-compassion and optimism-enhancing self-help exercises over short periods of time for individuals experiencing symptoms of depression.

In the second study, Kelly, Zuroff and Shapira (2009) examined two self-help interventions in distressed acne sufferers recruited through local online and newspaper advertisements, mostly undergraduates. The two arms were self-soothing (n=23) and attack-resisting (n=24), there was no control arm. After two weeks, participants in the self-soothing arm reported lower levels of shame and skin complaints, but not lowered depression. Participants in the attack resisting intervention also had lowered depression scores. The authors speculate whether the self-soothing condition improved participants' abilities and whether the short, two week period of their intervention may have been insufficient to boost self-soothing behaviours.

These studies suggest self-compassion enhancing interventions may have positive impacts on shame and depression. However, the self-help nature of the interventions, recruitment

methodologies, short-term nature of the interventions and relatively small numbers of participants mean their findings should be considered with care.

Whilst CFT is a predominantly western construct, research does take place elsewhere. Lo (2014) examined self-compassion within East Asian Confucian societies. In an RCT featuring 82 Chinese with mild to moderate depression and anxiety, Lo reports medium to strong effect size reductions in symptoms, outcomes were sustained at three month follow-up. In Iran, researchers conducted an RCT involving 19 depressed patients selected from a psychiatric clinic (Noorbala, Ahmad, & Noorbala, 2013). Compared to control, patients undertaking CFT reported significantly decreased depression and anxiety at follow-up. Whilst this is a small-n study, it is also one of the few RCT's to evaluate CFT treatment outcome.

2.4.4 Other Mental Health Difficulties

It's been argued that self-compassion based interventions could be of value in a range of difficulties. Theoretical and/or outcome studies have now been published covering areas including; non-suicidal self-injury (Van Vliet & Kalnins, 2011), survivors of intimate partner abuse (Tesh, Learman, & Pulliam, 2013), personality disorder (Lowens, 2010; Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011; Lucre & Corten, 2013), eating disorders (Gale, Gilbert, Read, & Goss, 2014; Goss & Allan, 2014; Kelly & Carter, 2014), problematic alcohol use (Brooks, Kay-Lambkhin, Bowman, & Childs, 2012) acquired brain injury (Ashworth, Clarke, Jones, Jennings, & Longworth, 2014), trauma (Thompson & Waltz, 2008; Beaumont, Galpin, & Jenkins, 2012; Beaumont & Hollins Martin, 2013; Bowyer, Wallis, & Lee, 2014), severe and enduring mental health difficulties (Judge, Cleghorn, McEwan, & Gilbert, 2012) and psychosis (Laithwaite, et al., 2009; Braehler, et al., 2013).

Most literature is theoretical, noting links between difficulties seen in people with these problems and the construct of self-compassion, before suggesting that clinical interventions based on self-compassion could be of value. The overall field is now too large to fully review. However, one paper has used IPA and three have reported mixed methods investigations of CFT:

Ashworth et al. (2014) report a mixed methods naturalistic service evaluation of an 18 week combination group and individual CFT programme for twelve patients with acquired brain injury (ABI). Quantitative data collection consisted of measures of mood and the Forms of Self-Criticism/ Self-Attacking and Self-Reassuring Scale (Gilbert, Clark, Hempel, Miles, & Irons, 2004). Measures were completed pre-post and at three month follow-up points. They report significant pre-post reductions in self-hatred and inadequate self as well as anxiety and depression. Gains appeared to be maintained at follow up.

Semi structured interviews were completed with six participants and analysed using IPA. The interview schedule was developed drawing on established literature regarding psychological change. Emergent themes are shown in table 2.1.

Table 2.1. Emergent Themes from Ashworth et al. (2014).

| Superordinate Theme | Subordinate Themes |
|-------------------------------|--|
| Psychological Difficulties | Self and world as unsafe Life Changes Self-Criticism Continuity vs discontinuity |
| A New Approach | It's not my fault – sense making New Tools Revaluing Self A new way to relate to others |
| Developing Trust and Safeness | Consistent Caregiver In it together – security in the group Environmental security |

Synthesising their data, the authors conclude that participants experienced self-criticism in the forms of both inadequacy and hatred towards the self. They do note that some issues might be specific to their population; anxiety and depression scores were only marginally clinical significant at outset and they saw improvements in inadequacy scores which are not reported elsewhere. Hatred towards the self is seen as a change which can be related to other published studies. Finally, they note that the focus on neuroscience and 'tricky brains' was helpful for people with ABI.

Overall, this was a small group evaluation with no control arm and some limits to the quality of its quantitative data. Its mixed methods approach is similar to this project although it might have done more to synthesise the findings from their two arms into one new set of findings.

Lawrence and Lee (2013) used IPA to explore the experience of becoming more self-compassionate for seven people with posttraumatic stress disorder. Trauma experiences varied from repeated childhood trauma to single adult traumatic episodes. Four participants took part in group CFT, three in individual CFT. Participants were drawn from clinical settings though the exact details of these settings were not made clear.

The authors adopted a conventional IPA approach and were clear regarding their own reflexivity. Five superordinate themes emerged as well as several subordinate themes (table 2.2). Each theme is supported in the paper by at least one quotation, often two from two different participants:

Table 2.2. Table of Themes Emerging from Lawrence and Lee (2013).

| Superordinate Theme | Subordinate Theme |
|---|---|
| The battle to give up the inner critic: Who am I if I am not self-critical | Fear of loss of self-identity The relationship between self-compassion and self-criticism |
| An aversive and alien experience. How it feels to develop self-compassion | Self-compassion is alien and a frightening experience I don't deserve self-compassion The desire to reject self-compassion and CFT: It feels hopeless |
| The emotional experience of therapy | The importance of the therapeutic relationship Feeling versus thinking compassion – realising it's not my fault I am not alone in my struggles |
| Self-compassion as a positive emotional experience | n/a |
| A more positive outlook in the present and for the future | Enjoying life rather than just living it A new sense of hopefulness for the future. |

This paper rates highly according to the principles for high quality IPA laid out by Smith (2011). Several themes appear to be similar to those emerging in Heriot-Maitland et al.'s (2014) paper, such as the positive experience of therapy and the positive emotional experience of self-compassion. In other respects, this paper appears to provide a more

balanced perspective of CFT from a participant's perspective. Gilbert (2009) writes about the difficulty clients may experience in accepting self-compassion into their lives and themes emerge in this paper to support that position. The authors also note the sense in which participants' narratives reflected a journey which therapy helped them to commence but which may continue beyond that timeframe. They also note the role of self-criticism in triggering threat-response schema, especially early in therapy. Gilbert argues that work on compassion-resistance can form the major part of work with more complex clients. Participants noted an emotional shift which took place through therapy, characterised by the experience of no longer feeling that they were to blame. Participants linked this experience to either being part of a group or the therapeutic alliance.

Lucre & Corten (2013) report a 16 session group CFT intervention for 8 white British people with personality disorders. Using a mixed methods design (quant + qual), the authors assessed outcome using a range of scales and measures administered pre/post and at 12 month follow up. They also conducted a content analysis of letters written by participants at the end of therapy as well as of written feedback.

Positive change was achieved on a number of measures, suggesting improvements in shame, social comparison, self-hatred, self-reassurance, depression, stress, emotional distress, perceived social functioning and wellbeing as well as perceived risk to self and others. However, the majority of these reported changes were observed on scales developed by Paul Gilbert and his team to measure key components of CFT. As such, they might be more likely to have shown change. Neff's self-compassion scale was not used in this study.

Qualitative analysis consisted of content analysis of letters written by participants at the end of therapy and of documented feedback from sessions. Four themes are reported, with between one and four extracts per theme. Little analysis is provided regarding the meaning of the themes emerging and the study is unable to offer any data regarding the mechanisms of change or key interventions, although they do speculate whether a greater emphasis on behavioural interventions might have been beneficial. Finally, there is only limited synthesis of the quantitative and qualitative arms of the study.

Nevertheless, the underlying intervention is reported to have led to seven of eight participants being discharged from mental health services by twelve month follow up. Broadly speaking, the improvements shown in outcome measures appear to be consistent with the theoretical literature.

Finally, Heriot-Maitland, Vidal, Ball, & Irons (2014) adapted CFT for use in acute inpatient settings into a four session methodology covering psychoeducation, mindfulness, compassion and imagery. The sessions were analysed using a mixed methods design using (n=57) pre/post custom measures of calmness and distress and qualitative interviews (n=4) analysed using deductive thematic analysis (Braun & Clarke, 2006). The team ran 22 sessions over a six month period. They had 93 attenders, 82 of whom completed pre-session measures and 57 post-session measures.

The authors argue that the significant reductions in distress and increases in calmness associated with the group and especially the imagery sessions, combined with connections between emergent themes and CFT theory, suggest that the intervention has promise. The study was intended to be a preliminary investigation and it adopts a mostly positivist and predetermined approach to understanding group outcomes. However it does appear to

extend CFT methodology and research into a challenging area and may show that even with considerable adaptation and complex clients, CFT may still be of value.

2.6 Conclusion

Gilbert's work on compassion focussed therapy sees it emerging as a significant presence in the pantheon of 'third-wave' cognitive behavioural therapies. There is a steadily growing international research effort underway to develop a meaningful evidence base. At the moment this evidence base consists of mostly small-n studies using a mix of quantitative and qualitative methodologies across a range of presenting problems.

From a positivist perspective, there is a serious lack of large-n randomised control trials and comparative studies with other methodologies. Additionally, the interventions that have been researched tend not to be manualised and therefore raise questions about the extent to which they can be considered 'CFT'. Finally, with only one widely used self-compassion measure (SCS) available, which is built from a different epistemological position to Gilbert's CFT, the validity of outcomes is open to question.

Nevertheless, looked at from the pragmatic perspective of a working therapist, there are the beginnings of a solid evidence base and no evidence of contra-indications for treatment. However, it's possible there is some outcome bias in the published studies. From the perspective of a therapist working in learning disabilities, there are no papers published in this field. This is not unusual and therapists may need to take a pragmatic approach to interpreting the overall evidence base.

My interpretation of the general background writing and published literature base is that there appears to be face validity for the use of CFT as a third wave CBT intervention. When

combined with anecdotal evidence of professionals in learning disabilities using CFT, the time seems right for a preliminary investigation. It is also noteworthy that a number of studies have adopted a mixed methods approach to their investigations.

Chapter 3. Methodology

3.1 Study Aim

The aim of this study is to investigate the experiences of adults with Learning Disabilities and Anxiety undertaking a course of Compassion Focussed Therapy.

3.2 Research Design

This project will involve three single case studies. The intervention will involve a 12-15 week course of CFT (Gilbert P. , 2010a; Gilbert P. , 2010b; Welford, 2010), in keeping with NICE guidelines for high intensity psychological interventions for anxiety (NICE, 2011). Three months post intervention there will be one more quantitative data collection meeting.

The National Institute for Health and Care Excellence (NICE) produces evidence based recommendations across a range of health and care topics. NICE Clinical Guideline 113 {CG113} (NICE, 2011) covers treatment for generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. It represents the baseline guidance for treatment of anxiety disorders in adults in England.

For people with GAD and marked functional impairment, CG113 recommends either high-intensity psychological intervention (CBT or applied relaxation) or drug treatment. Where CBT is offered, guidelines recommend that it be based on manualised programmes used in clinical trials. It is at this point that this investigation becomes experimental rather than a service evaluation as the form of third wave CBT being offered in this study did not form part of the evidence base considered when the guidelines were published in 2011.

Consequently the study required NHS Ethics approval before proceeding (see section 3.4).

Working from a pragmatic epistemological position, the project will be a mixed methods design (explanatory QUAL + quan). The inclusion of a qualitative arm will help 'give voice' to frequently unheard people (Larking, Watts, & Clifton, 2006). Using Interpretative Phenomenological Analysis, it will provide a rich picture of the participant's experience of therapy and their feelings of self-compassion. By examining clinically significant change in established measures of mood and self-compassion, the quantitative arm may provide a method for evaluating participant experience which is rooted in existing research.

Both quantitative and qualitative data collection will take place sequentially within each case study but may take place concurrently across studies. Mixed methods designs in Counselling Psychology have been reviewed by Hanson et al. (2005). Hanson encourages their use, arguing that such designs have become widely accepted in the broader social sciences literature and noting that numerous Counselling Psychology Journals now regularly publish mixed methods research.

3.3 Epistemology

Epistemology as applied to scientific theory attempts to understand the relationship between shared theories of knowledge and 'truth'. The term 'paradigm' can have multiple connotations from the most general such as a worldview, an epistemological stance or shared beliefs in a research field to the most specific such as model examples (Morgan D. L., 2007). Paradigms represent socially constructed categorical positions, with arguments about the unique contribution of each often appearing to emphasise their differences rather than their similarities. Within Counselling Psychology research, numerous paradigms are used, including but not restricted to positivism, phenomenology, social constructionism, critical realism, pluralism and pragmatism.

Understanding the differences between paradigms can be approached through exploring their positions regarding language and reality, their axiological, epistemological, methodological and ontological positions, their approaches to generalisation (Teddle & Tashakkori, 2009) or attempting to understand their claims for knowledge (Cresswell & Plano Clark, 2011, p. 40). Against this background of multiple paradigms and interpretative tools, paradigm selection may often take place concurrently with the formulation of research questions and methodology selection.

This project will adopt a mixed methods approach, integrating qualitative interview analysis with the use of quantitative data from forced choice preference questionnaires. The research question enquires about the experience of people with LD undertaking CFT. An experiential focus to the question suggests a qualitative methodology and phenomenological approach. In recent years, IPA has emerged as a dominant phenomenological methodology, combining phenomenological, hermeneutic and idiographic paradigmatic positions into a single framework (Smith, Flowers, & Larkin, 2009).

Alongside this in depth investigation, clinical effectiveness will be assessed by completion of pre/post measures of anxiety and self-esteem. Self-esteem and anxiety measures can be assessed descriptively and for clinically significant change (Jacobsen & Truax, 1991). The use of forced choice preference questionnaires and case level statistical analysis represents an adoption of a positivist paradigm. As such the epistemological position of this arm of the research might not be directly compatible with the phenomenologically oriented epistemology of IPA.

Data will be synthesised across these two arms of the study and therefore across paradigms. In order to achieve this, an overarching epistemological position will be required which can

balance the epistemologies inherent in the different arms. However, Thomas Kuhn (Kuhn, 1996 in Teddlie & Tashakkori, 2009) argued that paradigms were incomeasurable, that data from one paradigm cannot be directly compared to data from another. He was in effect arguing that having adopted one understanding of 'truth', it is not possible to then adopt another one and to combine understandings based on different 'truths'.

Not all writers agree regarding the incomeasurability of paradigms and a body of mixed methods writing exists endorsing cross paradigm data integration. Specifically, Hanson et al. (2005) recommend mixed methods research for Counselling Psychology research and argue that pragmatism is the key to doing so. In contrast to Kuhn's position, Pragmatism provides an epistemological position which is able to combine data developed from different 'truths'.

Cherryholmes (1992) argues that pragmatic research should be driven by anticipated consequences. In this sense pragmatism shifts the focus from registering past experiences onto the contribution of research in helping to organise future observations and experiences and therefore becomes less concerned with 'truth' than with 'usefulness'. Pragmatism's understanding of 'truth' consequently arises from the assertion that 'truth' can simply be understood as the attribution of the property of 'useful to believe' to an assertion.

Truthfulness should therefore be evaluated based on how accurately an assertion predicts the future rather than how accurately it describes reality.

Abandoning the concept of a fixed understanding of 'truthfulness' about past experiences might leave researchers feeling that they lack direction regarding methodological choices. However, Cherryholmes also calls for pragmatic research to be rooted in the researcher's own social values. In this case, the hoped for change in future observations and experiences would be a greater awareness amongst therapists of the utility of CFT when working with

adults with LD. This reflects my own social values as an advocate of therapeutic support for people with learning disabilities, who have historically been denied such resources. The most useful approach to achieve this goal may be to conduct research which can evidence change, suggest reasons for those changes and then ensure that findings are communicated to the body of professionals working in the field. Quantitative research methodologies seem well placed to evidence that a change in clinical presentation has occurred. Qualitative research seems well placed to explore the participant's experience of that change and the processes through which it might have taken place. Mixed methods research would therefore seem well placed to explore both clinical change and the manner in which that change might have taken place and been experienced.

Pragmatism particularly suits mixed methods research and is argued to represent a body of shared beliefs in the field (Teddle & Tashakkori, 2009). Pragmatism rejects the dichotomous position that quantitative and qualitative methods represent opposing poles, considering them to exist on a continuum with mixed methods in the midground. It acknowledges the value of inductive, deductive and abductive logic in research, allowing the logical positions of both quantitative and qualitative research to coexist. It acknowledges that subjectivity and objectivity exist along a continuum, which a researcher may move along within their project, sometimes engaging in analysis of subjective experience and at others utilising objective measures. Pragmatism acknowledges the existence of an objective reality independent of our own experience whilst accepting that we can only know how we experience that reality. Pragmatism accepts idiographic and case study research on their own terms, but also considers issues of generalisability and external validity when relevant.

A pragmatic paradigm is therefore well suited to mixed methods research, allowing the integration of quantitative and qualitative research methods, when the aim of doing so is to best achieve the desired outcomes of the project.

3.4 Research Ethics and Governance

My study received a favourable ethical opinion from the East of England – Cambridge Central Research Ethics Committee on 2nd April 2013 (reference 13/EE/0058, see appendix 1). It also received Research Governance approval from the hosting NHS Trust (Norfolk Community Health and Care NHS Trust) on 2nd April 2013 (reference 2013LD01, appendix 2) and from the University of East London School Of Psychology Ethics Sub-Committee (appendix 3).

A significant ethical and design issue has been separation of the researcher from the therapy. Norfolk is a large rural county in which the learning disability service is provided from five geographically separate bases.

A Counselling Psychologist colleague will deliver the therapeutic interventions. Researcher and therapist are located in different team bases, 36 miles apart with separate line management and clinical supervision. A protocol has been drawn up (appendix 4.) to define and maintain boundaries between myself and the therapist. I will meet the participants to consent them into the study and to carry out data collection. The therapist will continue to access clinical supervision within existing NHS processes independently of the research process.

3.5 Research Questions

3.5.1 Overall Aim

To evaluate the experience of adults with learning disabilities and anxiety who undertake a program of compassion focussed therapy.

3.5.2 Qualitative Arm

Primary Research Questions

How do participants experience a course of compassion focussed therapy for anxiety?

How has participants' perceived sense of anxiety and self-compassion changed following a program of compassion focussed therapy?

Secondary Research Question

To what extent does the existing self-compassion literature explain themes from participants' accounts of therapy and personal change?

3.6 Participants

Participants will be adults with mild to moderate learning disabilities, who have been referred for psychotherapy in connection with anxiety. Identification of mild to moderate learning disability will be based on a review of the potential participant's clinical history and the clinical judgement of the researcher and therapist. Routine clinical practice would rely on this type of clinician judgement to evaluate suitability for psychological therapy, and this research will respect the same clinical judgements.

Anxiety will be directly assessed within the quantitative arm of the study. Both major diagnostic systems contain a category for anxiety disorders, with several subcategories for specific subtypes. In DSM-IV (American Psychiatric Association, 1994), the categories are:

300.02 Generalized anxiety disorder

Panic disorder

300.21 With agoraphobia

300.01 Without agoraphobia

300.22 Agoraphobia without history of panic disorder

300.29 Specific phobia

300.23 Social phobia

300.3 Obsessive-compulsive disorder

309.81 Posttraumatic stress disorder

308.3 Acute stress disorder

293.84 Anxiety disorder due to a general medical condition

293.89 Anxiety disorder due to... [indicate the general medical condition]

300.00 Anxiety disorder NOS

In ICD-10 (World Health Organisation, 2010), the categories are:

F40 Phobic anxiety disorders

F41 Other anxiety disorders

F42 Obsessive-compulsive disorder

F43 Reaction to severe stress, and adjustment disorders

F44 Dissociative and conversion disorders

F45 Somatoform disorders

F48 Other nonpsychotic mental disorders

In this study it will be sufficient for the participant to achieve the threshold for diagnosis on the chosen measure of anxiety (GAS-ID). The specific class of anxiety (i.e. obsessive-compulsive disorder vs. phobic disorder) is not relevant for potential participant inclusion in the study.

Counselling psychology can appear to have a complex relationship with diagnostic categorisation of distress (Larsson, Brooks, & Loewenthal, 2012). The use of labels such as 'learning disability' or 'anxiety' implies an acceptance of the medical model and its underlying positivist epistemology. Whilst these terms are in widespread use within the NHS (Golsworthy, 2004), Counselling psychology has a value base which is not entirely in keeping with them. The humanistic epistemological position underlying counselling psychology (Strawbridge & Woolfe, 2010) suggests a rejection of labelling and the idea that any one belief system can be 'right'. Instead, a focus should be placed on understanding the client's unique phenomenological experience of distress.

While the profession of Counselling Psychology continues to debate these issues, for this study I shall adopt a pragmatic epistemological position to resolving these concerns. I will also seek to follow the guidelines for psychotherapy research offered by Goldfried and Eubank-Carter (2004). These authors argue that psychotherapy research should not be solely focussed on outcomes of carefully controlled trials (i.e. randomised control trials) but should also maintain a focus on exploring the processes of change within psychotherapy. In essence they argue for a balancing of process and outcomes research. Accepting this argument, this research project will attempt to explore the participants changing experience of distress and of their experience of therapy. It will also examine the degree to which any measurable change occurred and whether a change in the participant's diagnostic status

occurred. It will therefore be attempting to balance process and outcomes research within the same design; asking not just 'did change occur' but also 'what change occurred'.

By accepting the language of diagnosis within the quantitative arm of the study, it is possible to hope to create change in the future actions of psychologists working with the labels of 'learning disability' and 'anxiety' and as such to fulfil the demands of a pragmatic epistemology.

3.6.1 Recruitment

Sampling will be purposive and opportunistic, drawing from the normal caseload of a community learning disabilities team in Norfolk. Participants will be matched by cognitive ability, broad age and psychiatric diagnosis as recommended by Nezu & Nezu (1994) in order to achieve homogeneity. In practice, this will mean they will all have mild to moderate learning disabilities, be of adult age and referred for support regarding anxiety. Participants will be offered the option of treatment as usual or participation in research. Diagnosis of anxiety and mild learning disability will be confirmed in the initial screening.

In practice, all potential participants were referred through normal channels onto the community team psychology waiting list. Referrals were from either the participant's GP or from their social worker who had been in contact with them to complete an annual review of their care and support arrangements. Community learning disability team psychology waiting lists can include referrals for a wide range of issues such as psychological therapy for a wide range of presenting issues, specialist diagnosis, mental capacity assessment, multi-disciplinary team or family support or functional analysis of behaviours that challenge.

Participant selection therefore involved a learning disability specialist psychologist initially screening referrals on the waiting list by reading the referral and clinical notes as well as speaking to people in the team who knew the individual. The aim was to confirm that the individual required individual psychological therapy for anxiety and appeared to meet the inclusion/ exclusion criteria for the study.

It is not routine clinical practice in the Norfolk Learning Disabilities Service to conduct a formal learning disability assessment before commencing psychological therapy, instead the clinical judgement of the psychologist offering therapy is relied upon to assess eligibility. For the purposes of this study, the same clinical judgement was relied on to evaluate eligibility (and therefore also in this case that they met the cognitive functioning aspects of the inclusion/ exclusion criteria). Doing so ensured that participants received treatment as usual in all regards except the target intervention. Had they also received a full learning disability eligibility assessment then this would have created a further unique aspect to their treatment in comparison to treatment as usual over and above the use of Compassion Focussed Therapy.

3.6.2 Inclusion/ Exclusion Criteria

Inclusion criteria will include diagnosed mild to moderate learning disability and anxiety.

Exclusion criteria will include the presence of an autistic spectrum disorder due to its potential impact on the individual's conceptualisation of self-compassion and the self. A non-affective co morbid psychiatric disorder will also be an exclusion criterion. Anxiety disorders and depression can have high levels of comorbidity; a diagnosis of depression will not be an exclusion criterion.

3.7 Process from the Participant's Perspective

From the potential participant's perspective, figure 3.1 summarises the steps they will experience.

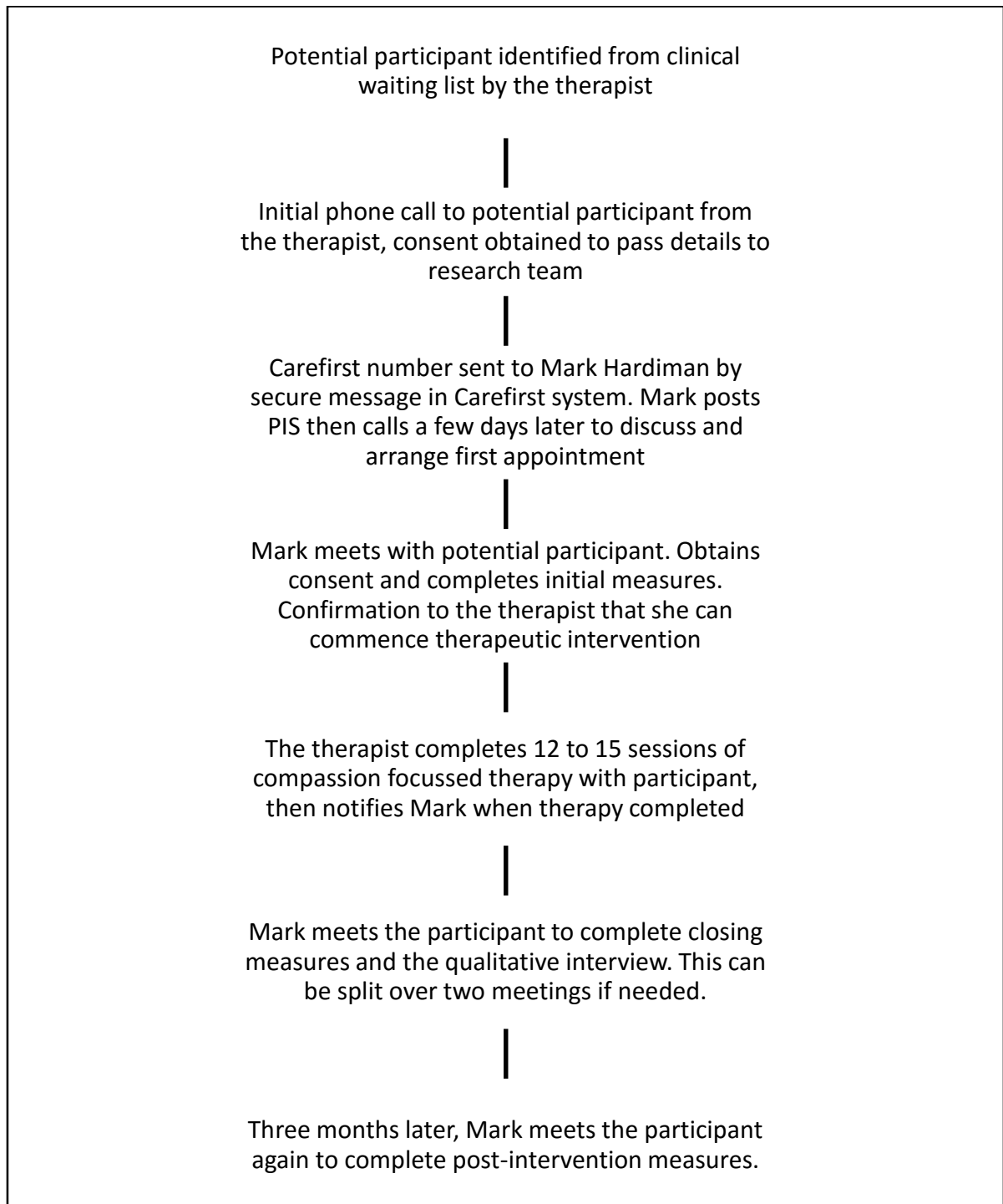


Figure 3.1. Participant Process Flowchart.

3.8 Documentation

The main participant documentation (Participant Information Sheet and Consent Form) was modelled on the standard templates provided by the National Research Ethics Service (2010).

Forms were then adapted into an easy read format using symbols and simplified language.

This process took place with the support of a Learning Disabilities specialist Speech and Language Therapist (Rebekah Mynett). Forms were then trialled informally with a sample of service users and final adaptations made before submission as part of the NHS Ethics process. In the end, limited changes were made.

3.9 The Clinical Intervention

3.9.1 Using Novel Therapeutic Interventions with people with Learning Disabilities

There are no reported studies investigating self-compassion or CFT amongst individuals with LD. There is evidence already discussed regarding its utility in mainstream services and many interventions do carry over effectively from adult mental health into LD services. As already discussed, mindfulness approaches in LD, which share common ground with CFT are now well researched and established (Martinez-Cengotitabengoa M.-T. , 2001; Morgan P. , 2009; Yildiran & Holt, 2014; Chapman, et al., 2013; Singh, et al., 2013). In addition, clinical colleagues believe CFT to be effective and are using it in their work with adults with LD.

Adults with LD can appear to have limited insight into their cognitions and emotions as well as expressive and receptive language difficulties. Third wave CBT interventions have proven effective with these individuals (ibid.). They shift the focus of intervention from changing

cognitions to changing people's relationship with those cognitions. There is no reason to believe that CFT's efficacy in this field should be different to any other third wave intervention.

Further research into interventions in this area can be justified by the high rates of anxiety in adults with LD (more than one in twenty at any time) (Cooper et al., 2007) and the generally limited research base. The development of CFT in recent years and its apparent efficacy in mainstream adult mental health as well as its use in the LD field justifies expanding the research base.

3.9.2 Evaluating treatment protocol compliance

At the time the project was designed, no scales were available to assess CFT treatment, although such a scale has subsequently become available (Kolts, 2013) (appendix 8).

The therapist based their intervention on her clinical experience of using CFT with clients, specifically informed by writings from Gilbert (2010a) and Welford (2010) regarding the CFT model and its use with people with Anxiety. The therapist is a Learning Disabilities specialist psychologist and was able to adapt the methodology for the client group as needed.

3.10 Qualitative Arm

Qualitative data collection involved one interview with each participant within ten working days of the end of the intervention. Interviews were recorded and transcribed by me.

3.10.1 The Interview Schedule

An interview schedule was prepared (Smith, Flowers, & Larkin, 2009, p. 58) focussing on the participant's experience of therapy, self-compassion and how they feel they have changed

as a result of therapy (appendix 6). Topics were chosen around the general themes of anxiety, self-compassion and the therapeutic relationship. The number of questions in the schedule was slightly higher than normally recommended for this type of interview (ibid.) due to the possibility of more impoverished responses being obtained from adults with LD to open ended questions. The interview schedule was reviewed with a specialised speech and language therapist and trialled with a sample of adults with LD. Adaptations included simplification of language and sentence structure, checking of understanding during the interview and avoiding leading questions.

3.10.2 Interviews and Transcription

Interviews were conducted in participants' homes within ten days of their final therapy session. All interviews were recorded on a digital voice recorder and reflective notes were written post interview. Recordings were then transferred to a PC and transcribed using Express Scribe Pro (NCH Software, 2013) and Microsoft Word. During transcription, special effort was made to retain the sense of the interview as a joint construction in keeping with IPA's hermeneutic understanding of data (Shinebourne, 2011).

3.10.3 Interpretative Phenomenological Analysis (IPA)

Transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008; Shinebourne, 2011; Reid, Flowers, & Larkin, 2005; Fade, 2004). Smith et al. (2009, p. 51) argue that IPA is suited to small N studies, more so as the method has matured. IPA is an idiographic phenomenological methodology consistent with the case study nature of this research which tends to reject a 'top down' approach to data analysis in favour of a 'bottom up' approach richly connected with the participant's account (Reid, Flowers, & Larkin, 2005). It acknowledges the impact of the

manner in which transcripts are interpreted by researchers in an attempt to understand the phenomenological experience of the participant in relation to the research questions (Smith J. A., 2007; Larkin, Watts, & Clifton, 2006; Wagstaff, et al., 2014). IPA therefore provides a tool to explore the experience of participants as narrated during the interviews whilst also acknowledging the impact of the researcher in the process.

The probable outcome of an IPA interpretation of the transcripts will be a small number of themes found across transcripts which capture some aspects of the participants' experience (Smith J. A., 2011; Wagstaff, et al., 2014).

3.10.3.1 IPA Epistemology

IPA has complex epistemological origins to its attempt to make sense of '*how participants are making sense of their personal and social world*' (Smith & Osborn, 2008). It asks '*what can a research participant know*' as well as '*what can a researcher know*'. It is therefore phenomenological in the sense that it attempts to understand the '*person-in-context's*' (Larkin, Watts, & Clifton, 2006) experience of an event as opposed to the event itself (Smith & Osborn, 2008).

IPA takes a complex position with regards to what can be achieved in understanding another's experience. On the one hand, it acknowledges Merleau-Ponty's position (1962, in Larkin, et al., 2006) that personal experiences have a '*structure that spreads across space and time that can be communicated to others...*'. On the other hand, it also accepts Heidegger's argument that a phenomenological approach attempts to understand an experience on its own terms, but must necessarily always fall short of this ideal aim (Larkin, Watts, & Clifton, 2006). IPA sees the researcher's job as being to do the best job they can of

getting close to the participants experience, whilst acknowledging the ultimately impossible nature of the task (Smith, Flowers, & Larkin, 2009).

IPA is also interpretative, being aware of the hermeneutic undertaking of a researcher engaging with a research participant's account of their experience of an event (Smith J. A., 2007; Larkin, Watts, & Clifton, 2006; Wagstaff, et al., 2014). IPA understands the research process to involve a participant experiencing an event (phenomenology). They interpret this event in light of their own life experiences and position with the social world. They then attempt to communicate something of this experience to the researcher. The researcher then attempts to understand and interpret this attempted communication in light of their own life experiences and position, as well as their theoretical position. The interaction of the researcher and participant as two actors in this attempt to develop understanding are understood hermeneutically. More specifically, the researcher's efforts to interpret the participant's account are understood as a double hermeneutic where the researcher is attempting to understand the participants experience, but can only do so from within their own position in the world (Larkin, Watts, & Clifton, 2006; Smith & Osborn, 2008) and in the moment (Larkin, Watts, & Clifton, 2006). As such, IPA is idiographic, by which it means both focussed on the individual case, but also on a single experience (ibid.). IPA only claims to offer an interpretation of one participant's experience of one event, though it does allow for the aggregation of themes across multiple participants where they have all experienced 'similar' events (Wagstaff, et al., 2014, p. 11).

Heidegger specifically argues that we cannot do anything other than interpret in light of our fore-conception of the material (Heidegger, 1962 in Smith, 2007). Smith argues that our fore-conception of materials can act as an obstacle to interpretation, best minimised by

giving priority in our interpretation to new material rather than preconceptions (Smith J. A., 2007; Cornish & Gillespie, 2009). Thus, IPA becomes an inductive methodology (Smith J. A., 2004) in which understandings emerge as much as possible from an in-depth analysis of new materials.

Analysis in IPA can take place at a number of different levels. Ricoeur (1970, in Smith, 2004) and Wagstaff (2014) argue for a hermeneutics of meaning and a hermeneutics of suspicion. Smith sees the first as a hermeneutics centred in empathy and meaning recollection. Larkin (2006) warns that this can be a tempting level of analysis at which to stop if working with voices that are not normally heard. He sees the second as a hermeneutics of critical engagement. Analysis in IPA attempts to move from the first to the second. Smith (2004) argues that *'Within such an analysis, the empathic is likely to come first and may then be qualified by a more critical and speculative reflection.'* This second form of hermeneutics is the level at which engagement with theory takes place. Smith (2004) is clear that engagement with theory should, so far as possible, emerge from the material rather than be imposed upon it. In this way, the analysis remains rooted in participants' experience but is able to expand out from there to critically engage with theory. It is also at this level of analysis that the researcher may speculate about the unsaid in the interview. IPA acknowledges that it is not possible for people to fully express their inner world and the researcher has a duty to help them through interpreting their efforts in light of broad psychological understanding and theory (Larkin, Watts, & Clifton, 2006).

3.10.3.2 IPA Methodology

Smith (2009) describes a plan for IPA analysis (table 3.1). However, he stresses this is only one way to conduct an analysis and other approaches can be taken (see also Wagstaff, et al. (2014)).

Table 3.1. Recommended IPA Analysis Steps. Adapted from Smith, Flowers & Larkin, 2009 Chapter 5.

| Step | Title | Details |
|---------|---|--|
| Step 1: | Reading and re-reading | Engaging with the material, adopting the participants' viewpoint, bracket off own impressions from interview |
| Step 2: | Initial noting | Close line by line analysis, annotate semantic content, descriptive, linguistic, conceptual comments |
| Step 3: | Develop emergent themes | Work with initial notes, focus on chunks of transcript, themes reflect original transcript and analysts interpretation |
| Step 4: | Search for connections across emergent themes | Creative process, can involve abstraction, subsumption, polarization, contextualisation, numeration, function |
| Step 5: | Move to the next case | Repeat above process. Analysis will be influenced by previous themes but important to still allow new themes to emerge |
| Step 6: | Search for patterns across cases | Themes can emerge across one, two or all cases leading to creation of a table of themes |
| Step 7: | Integrate themes and theory | Interpret themes in relation to pre-existing theory and research. |

An important principle throughout an IPA analysis is to repeatedly move through the hermeneutic cycle of part-whole, sometimes considering one specific element of the analysis, and at other times considering the whole transcript (ibid.). Continual movement between these two perspectives helps keep the analysis rooted in the original data (Wagstaff, et al., 2014; Smith J. A., 2011).

IPA has been used within mixed methods research previously, mostly combined with the administration of self-report or clinical measures. Amongst others, Rizq & Target (2010) combined IPA with Adult Attachment Interviews to explore trainee counsellors' experience of personal therapy. Thornton et al. (2011) combined IPA with self-report assessments to explore perceptions of public health campaigns by people experiencing psychotic disorders.

3.10.3.3 IPA in Learning Disabilities

Despite the possibility of more limited responses to semi structured interview questions, research using methods such as IPA is recommended with people with expressive language and cognitive deficits in order to allow traditionally underrepresented groups the opportunity to have their voices heard (Lloyd, Gatherer, & Kalsy, 2006). Smith (2004, p. 49) specifically argues that IPA can be used with children with learning disabilities and that the researcher '*may need to take a stronger role in guiding them than is usual in IPA*'.

Published research using IPA amongst people with LD includes MacDonald, Sinason and Hollins' work exploring experience of and satisfaction with group analytic therapy (2003). Other studies include Wheeler (2007) who explored sexual identity, Mitchell, Clegg & Furniss (2006), Scior & Longo (2005) who explored experiences of in-patient psychiatric care, Baum & Burns (2007) exploring parental experience of having children removed into care and Ditchfield & Burns (2004) who explored womens' experience of the menstrual cycle. Most of

these papers do not discuss the adaptations required to conduct qualitative research with people with LD, perhaps reflecting the 'taken for granted' nature of such adaptations amongst professionals working in the field. Whilst Kroese (1997) argues that people with LD may exhibit memory problems, incomprehension, anxiety, recency effects and acquiescence which may all impact on the nature of their responses in a semi structured interview, MacDonald (2003) reviews the evidence suggesting that researchers can still obtain good responses following 'minor modifications' such as those mentioned earlier. When such modifications are made, MacDonald argues that people with LD are able to provide valid and meaningful self reports. As such, they should be able to contribute fully to an IPA based study and deserve the opportunity to do so.

3.11 Quantitative Arm

3.11.1 Measures

Quantitative data collection consisted of measures of anxiety and self-compassion. Initial assessment also included a mental health screening measure (table 3.2). A score obtained from a forced choice questionnaire may only provide limited insight into the phenomenological experience of a participant. Nevertheless, these questionnaires are based on existing research and theory and provide a method for linking the participants' experience with that research. They also offer an alternative approach to investigating experience and may be particularly valuable when working with adults whose expressive language may be limited.

Table 3.2. Timing of Measures.

| Time Point | Initial Screening | Pre Intervention | Post intervention | Three Month Follow-up |
|--------------|----------------------|---------------------|----------------------|-----------------------|
| Mini PAS-ADD | X | | | |
| SCS | X | X | X | X |
| GAS-ID | X | X | X | X |
| GDS-LD | X | X | X | X |

3.11.1.1 The Mini Psychiatric Assessment Scale for Adults with Developmental Disabilities (Mini PAS-ADD)

The Mini PAS-ADD is a reliable (Prosser, et al., 1998) screening tool for the assessment of mental health in adults with learning disabilities. It has good inter-rater reliability between assessors and trained psychiatrists (Kappa 0.7) (Costello, Moss, Prosser, & Hatton, 1997). It will be used to screen for co-morbid psychiatric disorders.

3.11.1.2 Self-Compassion Scale (SCS)

The SCS (Neff K. D., 2003) is a 26 item self-report measure. It measures a six factor model of compassion, consisting of three opposing pairs (Self Kindness/ Self Judgement, Common Humanity/ Isolation, Mindfulness/ Over-identification) and an overall self-compassion rating. Responses are on a five point visual Likert scale ranging from 'Almost Never' to 'Almost Always'. Items include questions such as 'When times are really difficult, I tend to be tough on myself'.

The SCS has been developed through the three studies reported in Neff (2003). Participants for two of the studies were undergraduate psychology students in a large southern US university (total $n=623$. It's unclear if any participants were included in both samples). The ethnic breakdown of the students was 58% white, 21% Asian, 11% Hispanic, 4% black and 6% other in study one, similar in study two. In study three, a small, self-selecting group of practicing Buddhists ($n=43$, mean age 47.00 years, SD 9.71) completed the measure. In this study, length of Buddhist practice correlated with higher levels of reported self-esteem. The SCS is therefore a measure developed from a sample of mostly white undergraduates (mean age 20.91 years, SD 2.27) drawn from a western university population.

Neff conducted a factor analytic study of the pilot questions. The best fit was a six factor model in which each of the three core components of self-compassion has a positive and negative factor and this is the model described earlier, although Neff's original hypothesised conceptualisation did not include positive and negative aspects to each component. With this model, the confirmatory factor analysis found the data fit the model adequately well (NNFI= .90, CFI= .91) with each factor loading significantly ($p<.001$). The SCS also produces a higher order factor for overall self-compassion, for which internal consistency of .92 is good.

Construct validity was assessed against measures which might be expected to show convergence with the conceptual understanding of self-compassion. It shows significant negative correlation with self-criticism (Self Criticism subscale of the DEQ, $r=-.65$, $p<.01$). It significantly positively correlates with social connectedness (Social Connectedness Scale $r=.41$, $p<0.1$) and with the Trait-Meta Mood Scale (Attention, $r=.11$, $p<.05$, Clarity, $r=.43$, $p<.01$ and Repair, $r=.55$, $p<.01$). Discriminant validity was assessed against measures of self-esteem and found to have significant positive and negative correlations against different

measures, though never more than $r=-.50$ (against the Rumination Scale). In all cases, the SCS aimed to be moderately correlated with measures which were considered to assess separate but related constructs. This broadly appears to have been achieved.

The SCS was compared to measures of mental health with and without controlling for self-criticism. It negatively correlated against the Beck Depression Inventory ($r=-.51$, partial $r=-.21$, both $p<.01$) and the Speilberger Trait Anxiety Index ($r=-.65$, partial $r=-.33$, both $p<.01$). It positively correlated with the Life Satisfaction Scale ($r=.45$, partial $r=.20$, both $p<.01$). Although self-criticism appears to effect correlations, the SCS remains correlated with established measures of mood distress and life satisfaction, whilst maintaining discriminant validity.

In study two, test – retest reliability over a three-week period was assessed. Correlations for the different components ranged between .80 (common humanity subscale) and .93 (Overall self-compassion). Overall, it appears adequately reliable and internally consistent, at least as a measure of overall self-compassion if somewhat less so for some subcomponents.

The SCS has been used in some CFT outcome studies, e.g. Brooks, Kay-Lambkhin, Bowman, & Childs (2012), Kelly & Carter (2014), Thompson and Waltz (2008). It has not been adapted for use in an LD environment.

Whilst adults with mild LD can provide good reporting using complex measures (Dagnan & Lindsay, 2004) some adaptations may be required to improve accessibility, typically involving simplification of language, a larger font and clearer layout. In this case, few adaptations were made as it was accepted that the form and response options will need to

be interpreted for the participant by the researcher. This is not ideal but the language used in the measure was deemed too complex to reduce to easy read standards.

3.11.1.3 Glasgow Anxiety Scale for People with Intellectual Disability (GAS-ID)

The GAS-ID is a 27 item self-report measure of anxiety (Mindham & Espie, 2003). Responses are on a three point visual likert scale ('never', 'sometimes', 'always'). Completion takes 5-10 minutes and it has good correlation with the Beck Anxiety Index ($r=0.75$), internal consistency ($\alpha=0.96$) and test-retest reliability ($r=0.953$, $p<0.0001$).

3.11.1.4 Glasgow Depression Scale for People with a Learning Disability (GDS-LD)

The GDS-LD (Cuthill, Espie, & Cooper, 2003) is a 20 item self-report measure using a three point Likert style visual analog response format. The authors report good psychometric properties, test-retest reliability ($r=0.97$) and criterion validity ($r=0.94$). The GDS-LD correlated well ($r=0.88$) with the Beck Depression Inventory II (Beck, Epstein, Brown, & Steer, 1988; Beck, Steer, Ball, & Ranieri, 1996).

3.11.2 Data Analysis

Statistical analysis consisted of both descriptive and inferential statistics. All analysis took place on a single case basis rather than by analysing consolidated case information.

Descriptive statistics were produced for pre/post and three month post intervention measures of anxiety, depression and self-compassion, including tables and graphs of absolute scores and changes.

Inferential statistics will assess for clinically significant change within each individual case. Jacobsen and Truax (1991) and Zahra & Hedge (2010) describe how the reliable change index (RCI) can measure whether individual change on measures with overlapping

‘functional’ and ‘dysfunctional’ populations can be considered statistically reliable broadly by examining whether mean values can be reliably be said to have changed.

3.11.2.1 Calculating Reliable Change Cutoffs

Reliable change requires that the score obtained when re-administering the measure changes by more than 1.96 times the test error (equivalent to being 95% confident that the change in scores is not attributable solely to measurement error).

To do so, the test error (in this case test-retest error) is first converted into the test Standard Error of Measurement (S_{EM}). This expresses the test-retest error in standard deviation units. The S_{EM} is then converted into test score units and expressed as the Standard Error of the Difference (S_{Diff}). Finally, this is multiplied by 1.96 to represent the degree of change in test scores which is required to be 95% confident that change is not due to test error (one tailed hypothesis – that scores will improve).

Thus:

$$RCI = X_2 - X_1 / S_{diff} \text{ where } S_{diff} = \sqrt{2 (S_{EM})^2} \text{ and } S_{EM} = S_1 \sqrt{[1 - r_{xx}]}$$

Where:

RCI = reliable change index

S_{diff} = standard error of the difference between two scores

S_{EM} = standard error of measurement for the test

r_{xx} = measure reliability co-efficient

S_1 = measure standard deviation

X_1 and X_2 = measure pre/ post scores

An RCI of 1.96 or more indicates that the difference in scores is likely to be a real difference (95% confidence level) (table 3.3).

Table 3.3. Reliable Change Index Calculations for Quantitative Measures.

| Measure | r_{xx} | S_1 | $S_{EM} =$ $S_1\sqrt{[1 - r_{xx}]}$ | $S_{diff} =$ $\sqrt{2 (S_{EM})^2}$ | $RCI = (X_2 - X_1)/$ S_{diff} , for $RCI \geq 1.96$, $X_2 - X_1 \geq$ (Note 1) |
|---------|---|-----------------|--|---------------------------------------|---|
| SCS | 0.93 (Neff, 2003) | 3.75 (n=391) | 0.99 | 1.4 | 3 Points |
| GAS-ID | 0.95 (p<0.0001; Mindham & Espie, 2003) | 3.51 (n=16) | 0.77 | 1.09 | 3 Points |
| GDS | 0.97 (p<0.0001; Cuthill, Espie & Cooper, 2003) | 2.94 (n=19) | 0.51 | 0.72 | 2 points |

Note 1: Thus a 3 point change is needed in Overall SCS and GAS-LD scores to give an RCI greater than 1.96 and allow us to reject the null hypothesis and accept that there is a 95% probability level that a real change has occurred in the individual.

Note 2: For the GDS, a 2 point change is needed to give an RCI greater than 1.96 and allow us to reject the null hypothesis and accept that there is a 95% probability level that a real change has occurred in the individual

3.11.2.2 Clinically Significant Change.

Matthey (2004) describes clinically significant change as whether or to what extent an individual has recovered following treatment, i.e. have they crossed a diagnostic threshold and moved on a scale from 'unwell' to 'well' and can that change be considered statistically significant (table 3.4).

Table 3.4. Definitions of clinically significant change (Matthey, 2004).

| Descriptor | Definition |
|----------------------------|--|
| Recovered | Indicates statistically reliable change according to the RCI and move from clinical to non-clinical range. |
| Improved but not recovered | Reliable decrease in scores according to RCI but remains within clinical range. |
| No change | Non-significant change according to RCI |
| Deterioration | Significant increase in scores according to RCI |

3.12 Data Synthesis

Cresswell & Plano Clark (2011, p. 217) describe the process of drawing inferences across differing arms of a mixed methods study. They explicitly argue that doing so is best approached from a pragmatic epistemological position. In this case, the positivist epistemological position of the quantitative arm will need to be integrated with the phenomenological position of the qualitative arm. From a pragmatic standpoint, this need not present too great a barrier to data synthesis since the test is whether attempting to integrate the data in this way will help achieve the research goals.

Practically in this case, the quantitative and qualitative arms were first analysed individually and inferences drawn for each arm. Next, meta-inferences were drawn from across the arms by merging data and comparing the findings with the original research questions. The overall aim of the meta-inference stage was to draw together the differing perspectives of the qualitative and quantitative arms into a single picture of the participants' experience of undertaking a course of compassion focussed therapy and to what extent the intervention

may have supported them to achieve symptom relief. This then provided a response to the overall aim of the research project.

Final data is presented using a mix of thematic tables and text (Smith, Flowers, & Larkin, 2009).

Chapter 4. Results

4.0 Research Questions

4.0.1 Overall Aim

To evaluate the experience of adults with learning disabilities and anxiety who undertake a program of compassion focussed therapy.

4.0.2 Qualitative Arm

Primary Research Questions

How do participants experience a course of compassion focussed therapy for anxiety?

How have participants' perceived sense of anxiety and self-compassion changed following a program of compassion focussed therapy?

Secondary Research Question

To what extent does the existing self-compassion literature explain themes from participants' accounts of therapy and personal change?

4.1 Recruitment

Recruitment took place as planned within a community learning disability team. Two clients were identified but did not enter the study. One client's difficulties became unmanageable in a community setting prior to consent and he was returned to a low secure unit under section 3 of the Mental Health Act 1983. I met with another client but during the consent interview I felt that it might not be in their best interests to participate in a research study which required them to receive only one model of therapy. I referred them back to the team psychology service which was able to offer them an intervention based on psychoeducation

and behavioural support via their support workers. This left three clients who were consented into the study and completed therapy as planned.

Two participants experienced significant life events during their involvement. MA lost his mother prior to follow-up and AW had an elective caesarean section during therapy. The impact of extra-therapeutic factors are well documented, partly because they can be so common. These are likely to have been factors which might play out in opposite directions on their general mental health and I felt no need to consider excluding either of them from the study as a result. They are simply examples of the sort of things that happen to people whilst they undertake a course of therapy.

4.1.1 Pen Portrait - Participant 1 - MA

MA is a 48 year old white British male with moderate learning disabilities who lives with his mother. MA is unable to read or write and appears at times to rely on echolalia and acquiescence in his verbal communication when he may be having difficulty following the conversation.

He has been fortunate to hold a number of supported employment jobs (e.g., Yard Cleaner) previously but these ceased three years ago following a back injury. His father died 18 years ago, his grandmother last year. His mother has physical health difficulties (she died shortly before post intervention data collection).

MA reports being '*a bit shaky*' when outside or near people. Also, '*my heart goes*' and he gets '*bit panic*' at times. He reports freezing when near roads. He walks alongside fences rather than on the roadside edge of paths and has trouble with crossing gaps.

4.1.2 Pen Portrait - Participant 2 - AW

AW is a 47 year old white British female with mild to moderate learning disabilities who lives with her parents. AW initially appears to be quite able, but with time together her cognitive difficulties become clearer.

AW has worked in the past (cleaning, laundry, washing up) but now attends day centres near her home. She was awaiting an elective hysterectomy, which took place while she was working with the therapist.

AW has experienced a number of deaths in her family, the subject of death continues to worry her. She describes feeling '*panicky*' when people upset her. She worries about her future and about meeting people. She fears going down stairs, doing so at home on her bottom.

4.1.3 Pen Portrait - Participant 3 - GP

GP is a 31 year old white British female with mild learning disabilities who lives with her husband and four children. She left school with no qualifications and has not worked.

GP has been the victim of rape by a former partner, has been sexually assaulted at a party and followed by a stranger in a local park. She is now unable to leave the family home on her own. This includes taking her children to school locally, as she would then need to walk home on her own (a distance of less than half a mile). GP believes it has been about five years since she was last out on her own. She undertook CBT based therapy about 18 months ago with little success.

4.3 Qualitative Analysis

Four superordinate and six subordinate themes were identified in the qualitative analysis (see figure 4.1 overleaf). The superordinate themes will be presented in an order which broadly parallels the experience of participants as they underwent therapy. Theme one – ‘I was Different to Others’ describes how they felt pre-intervention. Theme two – ‘Being Helped’ describes something of their experience of therapy. Theme three – ‘Experiencing Compassion’ explores their experience of one part of the therapeutic intervention. Finally theme four – ‘Understanding Change’ explores how they make sense of the process of change they have undertaken.

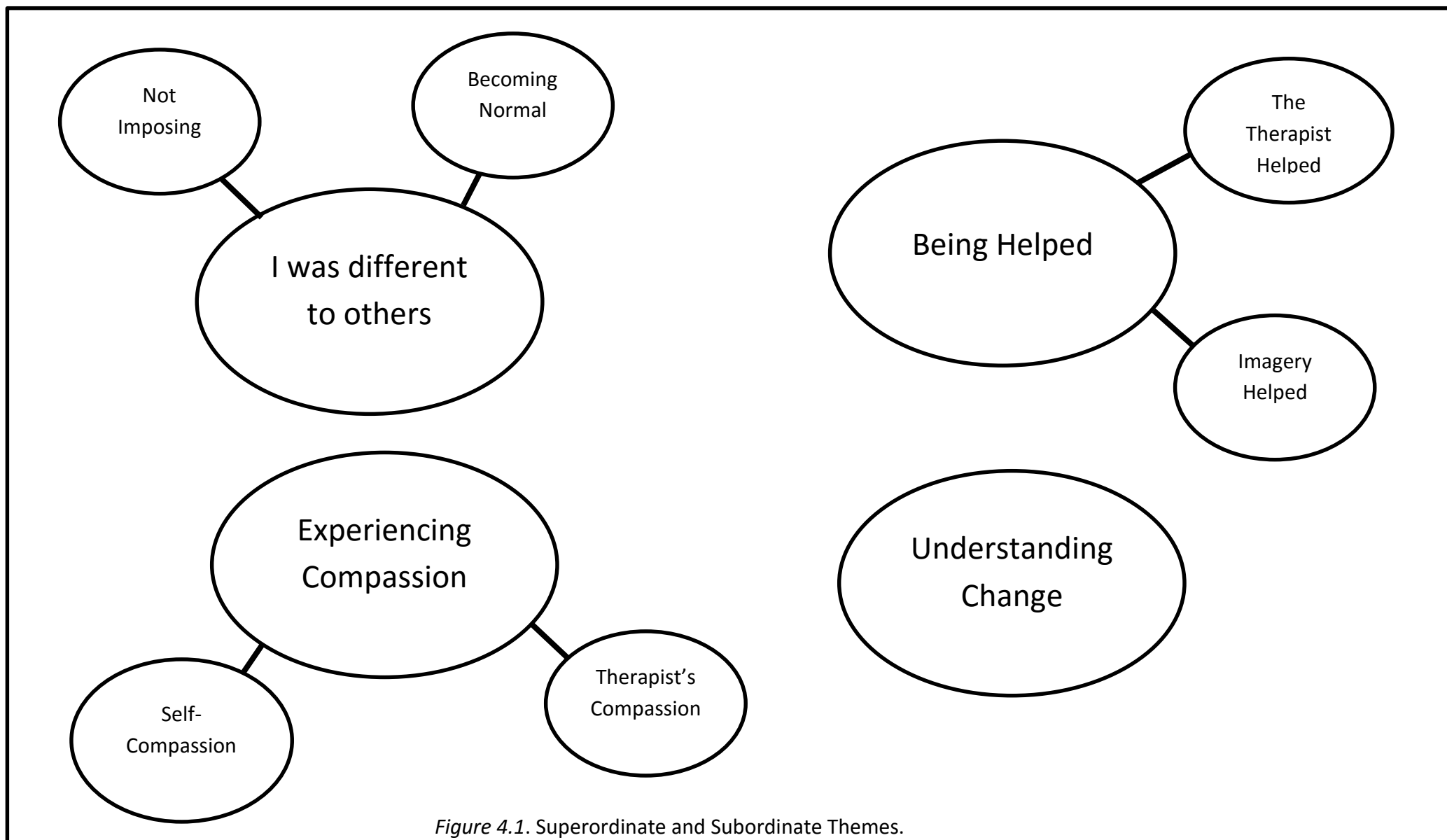


Figure 4.1. Superordinate and Subordinate Themes.

4.3.1 Superordinate Theme – I was different to others

All participants describe not feeling able to impose themselves on others before meeting the therapist; that they were in some way not good enough or not expected to show their distress to others. They describe their journey through therapy as one where they progressively become 'normal', like everyone else. Perhaps this represents a developing sense of common humanity.

4.3.1.1 Subordinate Theme – Not Imposing

All three participants described feeling unable to impose themselves on others.

- | | |
|----------|--|
| MA 374 | <i>Bother it up I do if some go um you know if something bother me up I'll do it</i> |
| Mark 375 | <i>Mm</i> |
| MA 375 | <i>Make me cry</i> |
| Mark 376 | <i>Mm</i> |
| MA 376 | <i>You know</i> |
| Mark 377 | <i>Mm</i> |
| MA 377 | <i>Haven't done that lately, I've been good</i> |
| Mark 378 | <i>No? you've been good</i> |
| MA 378 | <i>I've been good</i> |
| Mark 379 | <i>OK when was the last time</i> |
| MA 379 | <i>I can't remember now</i> |
| Mark 380 | <i>Right</i> |
| MA 380 | <i>I've been good I haven't been crying, you know</i> |

MA has been good, he hasn't cried. In the following extract he explains that this is good because he hasn't upset others:

- | | |
|----------|---|
| MA 578 | <i>I do get upset sometimes</i> |
| Mark 579 | <i>Mm</i> |
| MA 579 | <i>Not often</i> |
| Mark 580 | <i>Mm</i> |
| MA 580 | <i>I don't I don't talk about it or I I belt up I do</i> |
| Mark 581 | <i>Mm</i> |
| MA 581 | <i>If something 'set me I don't tell no one I don't tell me mum sometimes</i> |

Mark 582 *Mm why do you keep it to yourself*
MA 582 *You know I get I don't like people get upset*

He appears to perceive allowing others to become aware of his distress as something he mustn't do since it will upset them, which is bad. GP said something similar in the context of concealing her distress from her children. Whilst this is a culturally normal act for a parent to consider, it can be considered here in the context of all three participants discussing the concealment of their distress from others:

Uh I think they just thought I was like they kept asking me mummy scared kind of thing and so like questions what happened but you didn't really want to tell them kind of thing so yeah but no cos they knew I was going to therapy and the lady was helping me get out I suppose they knew that I was getting help kind of thing (GP 100)

AW also talked about concealing distress, in her case by not reacting if distressed by others. As with GP and MA, she appears to feel that it would be better for her to conceal her distress from others, to hold it hidden inside herself, rather than to allow it to be seen by others. AW sees this as a positive; now that she doesn't allow her distress to show, she gets on better with the person who has been causing her distress.

If someone upset me like if say like I'm in a group I don't walk out just uh sit there that's what I been doing... I get on with that girl more I'm a bit better at the minute (AW 35)

All three participants are therefore expressing a sense that their negative emotions are things that should not be expressed, their distress is not to be shown for fear of its impact on others. Perhaps for all three of them, not only is their distress not important enough to deserve to be shown to others but also they appear to feel a high degree of responsibility for any impact their negative emotions may have on others.

4.3.1.2 Subordinate Theme – Becoming Normal

All three participants describe a change in how they view themselves which can be described as becoming normal, no longer in some way less than other people.

- GP 51 *Just felt like normal for once like everyone else just walking about kind of thing. I still like keep an eye out over my shoulder just in case but not as bad as I was kind of thing*
- Mark 52 *Mm yeah just like everyone else*
- GP 52 *Yeah*
- Mark 53 *What's that like to think about*
- GP 53 *Uh just being like normal kind of thing*
- Mark 54 *So if you're now normal what were you before*
- GP 54 *I just felt different kind of thing like I was stupid from everyone else kind of thing*

GP describes a transition from being 'stupid from everyone else'. This phrase seems to capture the embodied and faulty self aspects of identity which are discussed elsewhere. For GP, the experience of becoming normal when she previously believed herself to be so fundamentally different to everyone else must seem dramatic. One way that she describes achieving this change is through the use of an imaginary shell when talking to people:

Uh just thinking like imaginary room or I did do one with the woman before stone? Imaginating like a shell kind of thing that you talk to kind of things like that helped yeah (GP 120)

Perhaps for GP the shell represents a way to maintain a sense of safety from people in the same way that her children have been for her at times. If so, then maybe this demonstrates an internalisation of the sense of safety she previously took from the physical presence of friends and family and as such is a direct representation of the role of CFT in developing her internal resources and sense of safety.

MA also described a shell, though for him the shell has been a safe place previously inhabited but no longer needed. As such, it may capture something of the dilemma of

protection that also affects GP. Resources which allow people to feel safe when they use them such as children or shells may allow a conditional level of functioning in the world when they are used, but may also limit the person's ability to develop new more adaptive resources.

MA 621 *Come back a bit out of me shell you know*
Mark 622 *Oh you come out your shell a bit*
MA 622 *(laughs) you that what I mean*
Mark 623 *Oh right yeah I do know well I think I know what you mean you tell me what you mean*
MA 623 *Well come out my shell you know you come out you get you get uh get better*
Mark 624 *Mm*
MA 624 *Out of the shell you know that that open*
Mark 625 *Yeah so you felt like you were like a little closed shell*
MA 625 *Ay*
Mark 626 *And now you feel like it's a bit open*
MA 626 *Little bit open*
Mark 627 *Mm is that a good thing or a bad thing*
MA 627 *Good thing*

MA's description of his shell opening clearly suggests ownership of the shell. It's not completely clear, but the shell appears to be more a part of him than a place for him to hide. Perhaps the shell represents his sense of being hidden away from the world in a safe place where no harm can come to him, but also perhaps where no one will need to see him either.

AW also describes becoming more engaged in the social world:

Mark 150 *Whats that I wonder what it is I wonder what changed for you*
AW 150 *Um I don't know I think that's seeing all the other people do what they can do what sort of ask me tell me that I've gotta do it*
Mark 151 *Which other people are you referring to*
AW 151 *Uh my friend Tina she live in them um flats at the back and uh my friend Laura cos she come all the way from Diss and um she go on the train backwards and forwards so she gotta go anywhere and I thought if they can do it they can go all over the place they do*

AW has described the recognition that she shares a common humanity with others as a source of motivation and encouragement for her to go out into the world herself. GP also recognises her shared humanity, choosing to describe this aspect of her understanding when asked about self-compassion:

- Mark 56 No. Very cool... we've started to talk about self about the self-compassion ideas and about whether you feel different from everyone else or the same as everyone else, um what do you think self-compassion means to you now*
- GP 56 Um we can all do things the same kind of thing and no-ones different*

The functional benefits of becoming more normal are described by GP. She was previously only able to take her children to school if an adult accompanied her so that she wasn't alone for the return journey. Now she is able to make that trip on her own. This extract also captures the complexity of her relationship with her children; they are at the same time people who need the protection of their mother, but also sources of protection for her against the threats of the social world.

- Mark 36 That's good yeah good. So this was all about you being anxious and not wanting to be on your own and not wanting to go out on your own um I think you've answered told me a lot about this but how has that changed since you met (the therapist)*
- GP 36 That's changed quite a lot cos I take the kids out on me own I can like I was walking Rhianna to school by myself say and I was walking to meet Katrina by myself so that's helped a lot yeah*

There is a sense of empowerment about this statement, she is now able to do something that most others have always been able to do. AW also describes feeling more empowered, in her case she feels more able to take social risks and speak first:

- Mark 126 What's changed then so why is why are you now talking to these people more*
- AW 126 Um sometimes you gotta speak before they speak to you sometimes*

MA best captured the sense of feeling empowered and no longer less than others when he talked about others not being able to force him to do anything:

| | |
|-----------------|---|
| <i>Mark 770</i> | <i>Mm what was it like when (the therapist) kinda said it's okay to do less</i> |
| <i>MA 770</i> | <i>Less you know 'at's me what do less</i> |
| <i>Mark 771</i> | <i>Mm</i> |
| <i>MA 771</i> | <i>No one can't force me do it</i> |
| <i>Mark 772</i> | <i>Mm</i> |
| <i>MA 772</i> | <i>N No No one can't force me</i> |
| <i>Mark 773</i> | <i>Mm</i> |
| <i>MA 773</i> | <i>At all</i> |
| <i>Mark 774</i> | <i>No on can force you to do it</i> |
| <i>MA 774</i> | <i>Do it yeah no</i> |

He appears to feel that he now has permission to assert himself; that others cannot make him do things he doesn't want to do. He has become like everyone else, normal.

4.3.1.3 Summary

All three participants describe having a sense of not wanting to impose themselves and their distress onto others at the start of therapy. By the end of therapy, all three describe a sense of empowerment, that they can now assert themselves in the social world in new ways.

4.3.2 Superordinate Theme – Being Helped

Being helped represents both a positive experience of a supportive intervention from the therapist, but also a disempowered sense of lack of agency on behalf of participants. Their understanding of meditation practices within the CFT model appears quite varied but largely focussed on their use to manage acute moments of distress rather than as a long term developmental practice.

4.3.2.1 Subordinate Theme – The Therapist Helped

All three participants position the therapist as a source of help, but more than that perhaps as the source of change in their lives. They understand her interventions in quite concrete terms and appreciate the simple experience of being able to understand and feel understood by someone, perhaps a rare experience in their lives.

Um cos I done I had er all that like in the past and er I seen different people and she she's the best er one I've seen. Since 1993 and the centre when I see the sta um governors' Wednesday they said that how much better I looked and I'm doing things a bit more yeah (AW 6)

You know you know she she done wonderful (MA28)

Um I just feel different I don't know why I think (the therapist) helped me a lot with the breathing and the room I don't know 'at just felt like a weight lifted off my shoulder kind of thing so when I was walking down the road with the kids I just felt I don't know that no one would harm me kind of thing so I don't know (GP 45)

The therapist is wonderful, the best and helped them a lot. Lack of agency is a well-established theme in the lives of people with learning disabilities, best captured in Seligman's description of learned helplessness (Seligman, 1972; Abramson, Seligman, & Teasdale, 1978). Perhaps given the extent to which their difficulties are seen as an endemic part of themselves, it is no surprise that the participants would feel that they lack the agency to address the issue themselves.

When discussing ways in which the therapist provided them with help, MA and AW provide quite concrete examples:

| | |
|----------|---|
| MA 289 | <i>She helped me get on the paths you know um</i> |
| Mark 290 | <i>Right</i> |
| MA 290 | <i>She helped me go in there I me in the shop I'm alright</i> |

Um sort of talk about um cos I was bullied last year and er she sort of helped me out what to do wi with that girl and er and uh now cos I'm next door all day I don't er hardly see anybody uh got different people in the group so a lot better (AW 10)

Um sort of doing everything she told me to do like making that memory box was quite good. Put everything in what I got and sort of done everything what she told me to do anyway. People reckon I look a lot better (AW 52)

MA describes direct support from the therapist, AW describes practical strategies which the therapist taught her to help deal with distressing experiences. Whilst GP also describes a seemingly concrete strategy taught to her by the therapist, it is in fact a cognitive strategy which she is describing:

Um well that helped quite a lot that cleared my head quite a lot so like she made me I can't think what it was think of like if someone was looking at me and I notice they were looking she made me think that they were looking at me cos I was sexy or pretty kind of thing so that help yeah so like think of the opposite kind of thing (GP 47).

MA describes direct support from the therapist, AW describes practical strategies which the therapist taught her to help deal with distressing experiences. Whilst GP also describes a seemingly concrete strategy taught to her by the therapist, it is in fact a cognitive strategy which she is describing:

| | |
|-----------------|---|
| <i>Mark 254</i> | <i>Um when you are feeling panicky, do you think (the therapist's) helped that get better or do you think</i> |
| <i>MA 254</i> | <i>Yeah she helped me bit better</i> |
| <i>Mark 255</i> | <i>Right</i> |
| <i>MA 255</i> | <i>I can understand her I did</i> |
| <i>Mark 256</i> | <i>You understood her</i> |
| <i>MA 256</i> | <i>Yeah</i> |

In this short exchange, MA spontaneously offers the observation that he felt able to understand the therapist, an experience that is sufficiently unusual to be worthy of unprompted comment. He repeats this assertion later:

She helped she uh she talk talk talk sense you know talk more clearer (MA 648)

The therapist '*talked sense... more clearer*' perhaps stands in contrast to many other experiences MA might have had in his life. GP also described her experience of being in relation with the therapist, though in her case she talked about how the therapist was able to (perhaps, was permitted to) push her to do things that she might not have done otherwise:

Um she make sure that I done something like three times and she kept pushing make sure that I do it kind of thing so if I had like night time I'd do an hour was my last one for Paul to leave me on my own I had to do that three times before I got used to it kind of thing we used to draw faces um one used to be right anxious and then little and then more and I was in the middle all the time so she knew that I was kind of getting better but I was never like on the first one I was always in the middle face so yeah (GP 126)

Overall, the therapist appears to have been a source of help for all three. They appear to perceive the therapist as a '*wonderful*' influence, who helped them by teaching both practical and cognitive strategies. She was understandable, talked sense and pushed them when needed. This theme hints at Seligman's ideas of learned helplessness in three people who are living in the community, one of them a wife and mother. Historically, these ideas may be more associated with people who may be perceived as less able, perhaps from institutionalised backgrounds. They may be less frequently associated with more able people living in community settings.

4.3.2.2 Subordinate Theme –Imagery Helped

Mindful breathing was felt to be helpful by all three participants. Compassionate Imagery was experienced more idiosyncratically. However, even mindful breathing appears to have been understood mostly as a focussed intervention to rely on when distressed, rather than as a regular practice (maybe MA saw it differently).

All three participants reported that aspects of mindful breathing and compassionate imagery work helped them:

- Mark 93 *Did she do any things with you any special things with you to help you to practice being calm*
- AW 93 *Um take er like deep breaths and like uh if I go to the centre and come home and then take me teeth out she normally say take five deep breaths and take them out and that's been a lot better*
- Mark 94 *Okay so deep breaths helps you to keep calm can you how d how does it feel like for you to do that what's it like doing the deep breaths*
- AW 94 *I just go (demonstrates deep breathing) like that and take five deep breaths*
- Mark 95 *And how di how does it feel to you to do that, what's it like*
- AW 95 *Uh not so not s not shaky once a time my hands used to shake and they ain't done that so much*
- Mark 96 *okay what do you think that's about*
- AW 96 *Just taking like deep breaths and and doing them five count bits*
- Mark 97 *And that's all helped*
- AW 97 *Yeah that have yeah*

Here, AW clearly connects the use of mindful breathing with reduced distress when removing her teeth. This emphasis on the practical aspects of mindful breathing continues when GP talks about how both mindful breathing and imagining a comfortable room helped her to go out on her own (perhaps by down-regulating her threat response):

- Mark 43 *Okay okay what was it about so you came to notice that people were just ordinary were just people. What was it do you think about the therapy that helped you to do that*
- GP 43 *Um mainly the breathing I used to do before I used to go out um just looking over my shoulder once helped me so I knew where they were going kind of thing or I used to stop and 'tend I was doing something so I could watch where people were going*
- Mark 44 *Okay do you still feel anxious sometimes*
- GP 44 *A little but not as much as I used to*

- Mark 45 *mm. So can you describe that difference for me I know that's a very difficult question*
- GP 45 *Um I just feel different I don't know why I think (the therapist) helped me a lot with the breathing and the room I don't know 'at just felt like a weight lifted off my shoulder kind of thing so when I was walking down the road with the kids I just felt I don't know that no one would harm me kind of thing so I don't know*

MA also described the helpful impact of mindful breathing. In his case though, he did not directly link the exercise to a particular stressor. This lack of a direct link was present throughout his interview, perhaps MA appreciated the mindful breathing exercise as a regular practice more so than either AW or GP:

- MA 326 *You know I like I like her deep breaths*
- Mark 327 *Right*
- MA 327 *I like like like exercise*
- Mark 328 *You like the deep breaths and the exercises*
- MA 328 *exercises yeah*
- Mark 329 *Yeah okay*
- MA 329 *Tha that tha did work*
- Mark 330 *Mm*
- MA 330 *That did work a load of times*
- Mark 331 *That helped work a load of times*
- MA 331 *Load of times*

GP described the creation of an imaginary comfy room as a key component of her treatment. She refers to this room several times throughout the interview as something she could think about whenever she needed to feel calm:

- Mark 22 *mm. what do you think would be if you were going to try and sort of say what happened, what what what couple of things would you say*
- GP 22 *Um the room helped me think of imagining room kind of thing um cant think of anything else*
- Mark 23 *Okay tell me something about that room*
- GP 23 *Um we made up like a room so I could think of a comfy room so when I was walking about I could imagine I was sitting in a room with a big TV and a bed and units and that in there*
- Mark 24 *Right. A place that you could go and feel safe*

MA describes how imagery of helpful cheerleaders helps him. Here he seems not to be referring to a specific instance of help, more a general sense of it as a helpful thing to do. He also mentions it as a morning activity, suggesting that it has an element of regular practice about it separate from specific times when he feels he needs helpful imagery:

- Mark 506 *Are cheerlea what sort of people are cheerleaders what would they what would they be like if you needed some help how would they help you*
- MA 506 *Help me get better*
- Mark 507 *They'd help you get better*
- MA 507 *Ah*
- Mark 508 *Mm*
- MA 508 *Get better you know*
- Mark 509 *Mm how would they help me understand how they would make you get better*
- MA 509 *They do pompoms and make the words out*
- Mark 510 *Right they do pompoms and make out the words*
- MA 510 *Words yeah*
- Mark 511 *Right okay*
- MA 511 *That's why I like em*
- Mark 512 *Right okay*
- MA 512 *Oh uh so I like em I like their pom poms*
- Mark 513 *Mm okay I kind of understand so they're using the pom poms and they're making sha making like word shapes n things yeah. OK what words would they make for you*
- MA 513 *Well 'at's alsorts*
- Mark 514 *Yeah? They can make all sorts of words*
- MA 514 *Uh*
- Mark 515 *Are there any special words they would make they would make for you if you were feeling panicky*
- MA 515 *Uh 'ang on she done everything ... you see I can't find it not that one... that is look that is you've got now*
- Mark 516 *Right oh this is what they would do is it*
- MA 516 *Ay um do like that*
- Mark 517 *Yeah so they do the M it's up to me. I can set the pace. This is very good. C carestaff with help me. H help me stay calm. A always be kind. E do my relaxation exercises. L Let me decide. So they spell out Michael*

| | |
|----------|---|
| MA 517 | <i>Uh</i> |
| Mark 518 | <i>Oh OK</i> |
| MA 518 | <i>Uh that that help me</i> |
| Mark 519 | <i>Right so when do you use this how when do you when do you look at that</i> |
| MA 519 | <i>Err like um morning times</i> |
| Mark 520 | <i>Morning times</i> |
| MA 520 | <i>Ay</i> |

It is noticeable that AW doesn't mention any form of compassionate imagery in her interview. Participants understanding, use and recollection of this type of imagery appears to be idiosyncratic, ranging from not recalled at all through to its use as a distraction or behavioural intervention when needed, on to a specific morning practice. However, what is not mentioned at any time in any interview is a sense of regular practice to develop mindful awareness or an internalised sense of compassion. When these exercises are discussed, it is largely in the context of using them as focussed behavioural interventions or as regular exercises.

4.3.2.3 Summary

In summary, participants appear to have found the therapist to be helpful. In fact, they appear to believe her to be largely agentic in their recovery. They also see mindful breathing and compassion meditations as helpful, but only as behavioural interventions. There is no obvious sense from the interviews of meditations having helped participants develop mindful awareness or internalised self-warmth.

4.3.3 Superordinate Theme – Experiencing Compassion

Naturally, compassion is a key theme in CFT. Participants may experience the therapist's compassion, or develop their own self-compassion. Given its central theme in CFT, this superordinate theme takes a top-down approach to understanding participants' experience.

4.3.3.1 Subordinate Theme – The Therapist’s Compassion

All three participants were asked about the therapist’s compassion. MA discussed the therapist’s calmness and that she listened:

She calm she listen you know you got troubles like I had I had a load of trouble I had she phoned not phoned up um I been crying she um on the ‘puter in a white cap she put word on there (MA 758)

When discussing self-compassion (MA744 onwards), he chooses to describe her calmness and that she listens. He positions these within a context where the therapist has helped him when he had trouble. In doing so, perhaps he is returning to what he understands, practical times when the therapist helps him, rather than trying to respond to a more abstract question about a complex topic.

AW also discussed the therapist’s calmness during a discussion about ways that the therapist might have helped her (AW38 onwards):

- | | |
|---------|---|
| AW 45 | <i>Mm like um calm when she walked in. um just uh sort of miss talking to her a little bit</i> |
| Mark 46 | <i>Yeah sure you told me when you first met you kind of you got nervous with strangers so but you’ve just said that you felt calm when (the therapist) was here tell me more about that what did you mean by that</i> |
| AW 46 | <i>Um sorta calm to talk to uh previously when I had counselling before I didn’t uh sort of feel that comfortable</i> |

AW describes experiencing the therapist as both calm and easier to talk to than previous counsellors. Once again, calmness seems to be the property of the therapist that is highlighted. What does this suggest of AW’s experience of calmness in others? Is the therapist calm whereas others are not calm, or is there some property of the therapist’s calmness that sets her apart from others? Maybe calmness is the best term participants can

use to make sense of their experience of encountering someone who is attempting to offer them a highly compassionate experience.

In contrast to AW and MA, GP did not talk about the therapist as calming or compassionate at any time. When asked about her experience of self-compassion, she initially discussed her realisation that she was the same as everyone else:

Mark 56 No. Very cool... we've started to talk about self about the self-compassion ideas and about whether you feel different from everyone else or the same as everyone else, um what do you think self-compassion means to you now

GP 56 Um we can all do things the same kind of thing and no-ones different

In theoretical terms, this might be described as developing a sense of common humanity, which Neff (2007a) describes as a sub-component of self-compassion. Two participants have described their sense of the therapist as being a compassionate (caring) person, the third has highlighted their growing sense of being the same as others, no longer seeing strangers as threatening. Perhaps all three are highlighting a sense that the world can be more caring, less threatening than they originally perceived it to be.

4.3.3.2 Subordinate Theme – Self-Compassion

I asked GP again about her experience of self-compassion:

Mark 169 mm... when she began to do that and she was beginning to think about self-compassion how did she describe all of that to you

GP 169 Um can't remember... I remember one of them having like where my heart used to beat fast but when I walk like past people now we drewed one where it didn't beat or anything or my hands used to sweat they just like normal kind of thing when I walk past people cos I think of that room so that calms me down kind of thing

GP describes the use of compassionate imagery to down regulate her threat response around strangers. Perhaps she is understanding self-compassion as the absence of the

unpleasant negative experience of feeling threatened. AW also focussed on the absence of risk of harm, this time the risk of self-harm:

- Mark 104* *Mm okay the therapist talked to you a lot about what we call self-compassion. What does self-compassion how would you describe self-compassion to someone what do you think it means*
- AW 104* *I never heard of that before*
- Mark 105* *Okay about being kind to yourself*
- AW 105* *No I wouldn't harm myself. No I wouldn't harm myself that ain't worth it*

For AW, being kind to yourself means not causing harm to yourself. What is absent in this response is a sense of being permitted to be kind to yourself. Maybe for GP and AW, self-compassion represents an absence of threat rather than a presence of compassion. By contrast, MA was able to offer a response which did imply some sense of a positive aspect to self-compassion:

- Mark 548* *Yeah feeling feeling good about yourself. Did she talk to you about self-compassion*
- MA 548* *Warm place*
- Mark 549* *Warm place yeah*
- MA 549* *(laughs)*

Here he is describing a compassionate image he has built with the therapist. Creating a sense of inner warmth is a key feature of CFT and he has highlighted that process in his response.

There is some difference in the manner that they have each responded to being asked about self-compassion. None of their responses could be considered detailed. Yet, between them they have highlighted a potentially down regulated threat response, the absence of a desire to self-attack and a sense of inner warmth, all of which can be seen as central features of self-compassion.

4.3.3.3 Summary

Direct discussion about self-compassion was not a strong feature of the interviews, despite direct questioning about it. Perhaps this is the most striking finding, that after completion of a CFT intervention, participants do not discuss self-compassion to any great extent, though taken as a whole the three transcripts may show some evidence of having internalised aspects of the concept.

4.3.4 Superordinate Theme – Understanding Change

All three participants described ways in which they have changed. There is a sense in which for all three participants their distress pre-intervention had an embodied, unchangeable state to it. GP described it in terms of her sense of self and identity:

- Mark 51 Cool so life is really moving on for you isn't it there's lots of change happening but I was interested in that comment you that uh it made you feel like everyone else. Tell me more about what you meant by that*
- GP 51 Just felt like normal for once like everyone else just walking about kind of thing. I still like keep an eye out over my shoulder just in case but not as bad as I was kind of thing*
- Mark 52 Mm yeah just like everyone else*
- GP 52 Yeah*
- Mark 53 What's that like to think about*
- GP 53 Uh just being like normal kind of thing*
- Mark 54 So if you're now normal what were you before*
- GP 54 I just felt different kind of thing like I was stupid from everyone else kind of thing*

Here, she describes moving from the state of being different from everyone else to being normal (perhaps, like everyone else). She appears to understand the process of change as being one in which her sense of self has changed from feeling less than others to being the same as others. This is a powerful theme for GP, repeated several other times in the interview:

Um I thought I was like cos I've got learning difficulties I thought I was thick kind of thing but then after passing me English I knew that weren't I was not different from anyone else kind of thing cos there was other people in there from nearly the same levels so (GP 73)

There is a sense of permanence about her description of herself as 'being thick' because she has learning difficulties. This statement seems to deny the potential for change, after all she cannot stop having learning difficulties. Perhaps to GP, being thick and therefore different or perhaps less than others is simply an accepted part of who she is, not something that can ever be changed.

Mark 161 mm... if you could say something to yourself kinda six months ago or before you met (the therapist) what would you say

GP 161 Uh... I didn't really say a lot about myself kind of thing just thinking that I was thick kind of thing and different from everyone else kind of thing

Mark 162 Mm and what would you say to that person that thought those things

GP 162 I was stupid kind of thing yeah

In GP 161, she again acknowledges her historical view that she was thick and goes on to say that she now thinks she was stupid to think that way. Perhaps for GP, the scale of the change is so dramatic that it feels like a categorical shift in view rather than a dimensional movement. Perhaps she now cannot imagine how she might ever have thought that way about herself.

MA also describes how he feels different now compared to before therapy, for him it was an embodied experience:

Mark 670 So what's the future hold for you do you think

MA 670 Get get better

Mark 671 Get better

MA 671 Get better you know

Mark 672 Mm how will you know when you're getting better

MA 672 Uh by um by bit changed

Mark 673 Mm
MA 673 By 'at's easy to tell a bit tense up
Mark 674 Mm
MA 674 Tense up sometimes
Mark 675 Mm

Although the language in this extract is slightly difficult to follow, it was clear in context that he was describing an absence of 'tense up' as a positive change. MA appears to understand his distress and recovery as an embodied experience. This is also echoed in the following extract where he describes being better at walking (and consequently is talking to more people) as the reason why he's getting better.

MA 606 I get I get I get a bit a little bit bet better
Mark 607 You're getting a little bit better
MA 607 Yeah
Mark 608 Why do you think that is
MA 608 I getting getting get a little bit comst getting getting better walking
Mark 609 Mm
MA 609 And erm I talk talk more people now
Mark 610 Right
MA 610 I used to
Mark 611 Mm
MA 611 Walking I say hello people

AW also describes an absence of physical symptoms as an outcome of therapy.

Mark 29 Okay so the work that you did with (the therapist), all that time that you spent with her, do you think it helped you
AW 29 Yes that did yeah
Mark 30 How so how did it help you
AW 30 Um I in't had them er panic attacks since I started er bit er talking to her and I ain't had that horrible feeling in my legs mm I get it in my leg

AW 94 I just go (demonstrates deep breathing) like that and take five deep breaths
Mark 95 And how di how does it feel to you to do that, what's it like

AW 95 *Uh not so not s not shaky once a time my hands used to shake and they ain't done that so much*

As with MA, AW seems to be understanding of the process of change in physical terms. She isn't describing changed cognitive or emotional processes but the absence of an unwanted physical experience. During the course of her therapy she had surgery which helped her feel physically better and to become less anaemic. She appears to be connecting her changes as a result of therapy with her changes as a result of the surgery:

AW 52 *Um sort of doing everything she told me to do like making that memory box was quite good. Put everything in what I got and sort of done everything what she told me to do anyway. People reckon I look a lot better*

Mark 53 *Mm what do you think about how you look*

AW 53 *Yeah*

Mark 54 *Whats it like to kinda feel that you look better*

AW 54 *Um bit more colour um don't really know*

Perhaps this finally captures something of the experience for all three participants. Their distress pre-intervention was so much a fundamental part of themselves that it wasn't possible for them to conceive of it being any other way. They needed external intervention; the 'surgery of therapy' to remove the faulty beliefs ('*I was thick*') or unwanted physical sensations ('*tense up*', panic attacks, shaking) that they could not remove themselves. This is a disempowered way to understand therapy, but perhaps consistent with findings elsewhere about the subtle manner in which learned helplessness permeates the language and meaning making of all three participants.

4.4 Quantitative Analysis

Measures of Self-Compassion (SCS), anxiety (GAS) and depression (GDS) were assessed pre-intervention, post-intervention and at three month follow up.

4.4.1 Self-Compassion Scale Scores

With regards to the SCS, overall scores and domain scores are reported. Statistically significant change is evaluated for overall self-compassion only (Figure 4.2; Table 4.1; Table 4.2) as also analysing it for the sub-domains would increase the risk of type-1 error with such a small sample size.

For MA, overall change in self-compassion was non-significant. For AW, pre-post changes were statistically significant, maintained and improved at follow-up. For GP, pre-post changes were statistically significant, maintained and slightly improved at follow-up.

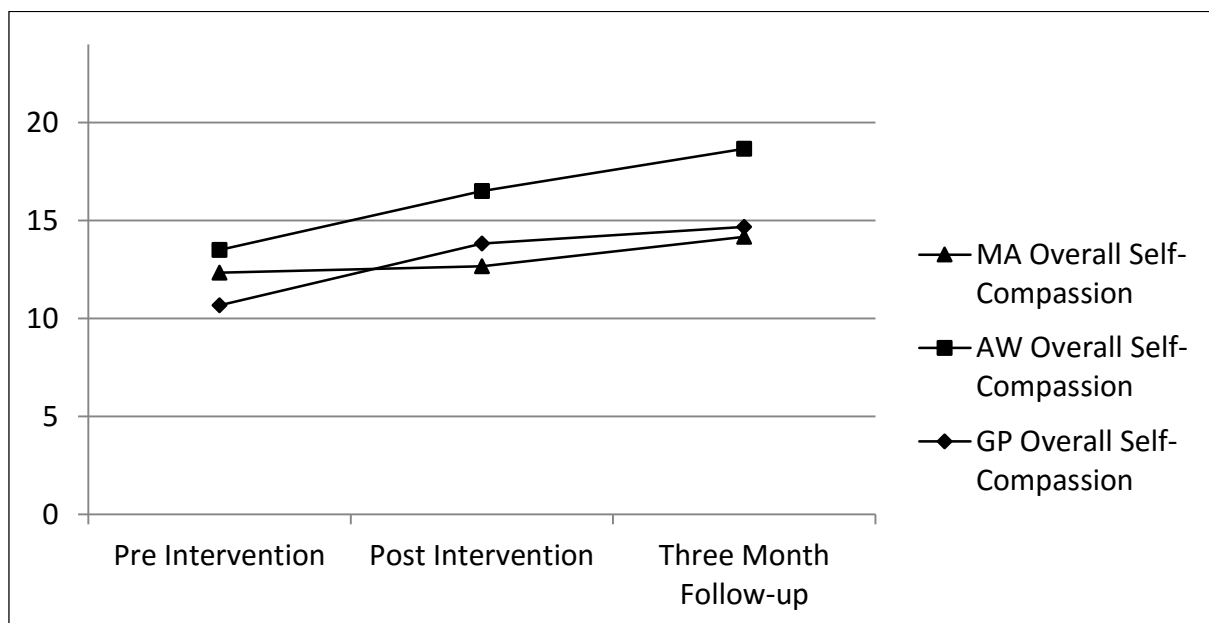


Figure 4.2. Overall Self-Compassion Scores.

Table 4.1. Self-Compassion Scale Domain and Summary Scores.

| Domain | MA | | | AW | | | GP | | |
|---------------------------------|------------------|-------------------|-----------------------|------------------|-------------------|-----------------------|------------------|-------------------|-----------------------|
| | Pre-Intervention | Post-Intervention | Three Month Follow Up | Pre-Intervention | Post-Intervention | Three Month Follow Up | Pre-Intervention | Post-Intervention | Three Month Follow Up |
| Self-Kindness | 1.60 | 4.20 | 4.20 | 3.40 | 3.60 | 4.60 | 2.60 | 3.80 | 3.40 |
| Self-Judgement | 1.00 | 1.40 | 2.20 | 2.60 | 1.40 | 1.20 | 3.80 | 3.00 | 2.20 |
| Common Humanity | 1.50 | 1.25 | 3.25 | 3.00 | 4.25 | 4.25 | 2.50 | 2.75 | 3.00 |
| Isolation | 2.75 | 4.25 | 3.00 | 2.75 | 2.25 | 1.75 | 4.50 | 3.00 | 2.50 |
| Mindfulness Over-Identification | 2.50 | 2.00 | 3.00 | 3.25 | 2.25 | 2.75 | 2.75 | 3.75 | 2.75 |
| | 3.00 | 3.00 | 4.00 | 3.75 | 1.75 | 2.00 | 2.75 | 3.25 | 2.25 |
| Overall SCS Score | 12.33 | 12.67 | 14.16 | 13.50 | 16.50 | 18.67 | 10.67 | 13.83 | 14.67 |

Note 1: A change of three points or more in overall SCS scores is statistically significant.

Note 2: Overall SCS scores do not represent the sum of subdomain scores but are calculated separately.

Table 4.2. Self-Compassion Scale Domain and Summary Changes.

| Domain | MA | | AW | | GP | |
|---------------------|-----------------|----------------------|-----------------|----------------------|-----------------|----------------------|
| | Pre-Post Change | Pre-Follow Up Change | Pre-Post Change | Pre-Follow Up Change | Pre-Post Change | Pre-Follow Up Change |
| Self-Kindness | 2.60 | 2.60 | 0.20 | 1.20 | 1.20 | 0.80 |
| Self-Judgement | 0.40 | 1.20 | -1.20 | -1.40 | -0.80 | -1.60 |
| Common Humanity | -0.25 | 1.75 | 1.25 | 1.25 | 0.25 | 0.50 |
| Isolation | 1.50 | 0.25 | -0.50 | -1.00 | -1.50 | -2.00 |
| Mindfulness | -0.50 | 0.50 | -1.00 | -0.50 | 1.00 | 0.00 |
| Over-Identification | 0.00 | 1.00 | -2.00 | -1.75 | 0.50 | -0.50 |
| Overall SCS Score | 0.34 | 1.83 | 3.00 | 5.17 | 3.16 | 4.00 |

Note: A change of three points or more in overall SCS scores is statistically significant

Across participants, self-kindness scores increased (improved) at post-intervention and follow up. Self-Judgement scores decreased (improved) at post-intervention and follow up for two participants, but increased (deteriorated) at both time points for the third participant (MA).

Common Humanity scores increased (improved) at both time points for two participants and increased at follow-up for the third after a slight reduction post-intervention. Isolation scores decreased (improved) for two but increased (deteriorated) for MA.

Mindfulness scores increased (improved) for MA, improved post-intervention but returned to baseline for GP and sustained improvement for AW. Over-Identification scores increased (deteriorated) for MA, decreased (improved) for AW though there was a slight deterioration between post-intervention and three month follow up scores, and for GP scores increased (deteriorated) post intervention but then reduced (improved) overall at three month follow up.

Looking at subdomain score changes for each individual participant, the largest change for MA was in Self-Kindness (2.60 point improvement both pre-post and pre intervention-follow up). The next largest changes were for Common Humanity (1.75 point improvement at follow-up) and Isolation (1.50 point deterioration at post-intervention, reduced to 0.25 points at follow-up).

For AW, the largest change was for Over-Identification (2.00 point improvement at post-intervention reduced to 1.75 points at follow-up). AW's other scores show a pattern of smaller changes (between 0.20 and 1.40) both at post-intervention and follow-up.

Mindfulness scores deteriorated, all other scores moved in the direction of improvement.

For GP, the largest change was a reduction in scores for Isolation (1.50 points at post-intervention, 2.00 points at follow-up). All other scores moved between 0.00 and 1.20 points). Over-Identification scores deteriorated by 0.50 points post-intervention but showed an overall improvement of 0.50 points by follow-up.

4.4.2 Glasgow Anxiety Scale & Glasgow Depression Scale Scores

With regards to anxiety, as measured by scores on the GAS, all three participants showed statistically significant improvement pre-intervention to three month follow up (figure 4.3; table 4.3). In all three cases, scores on the GAS remained above clinical cut-off post intervention and at follow up. In two cases, scores did not significantly change between post-intervention and follow up, in AW's case, scores reduced significantly.

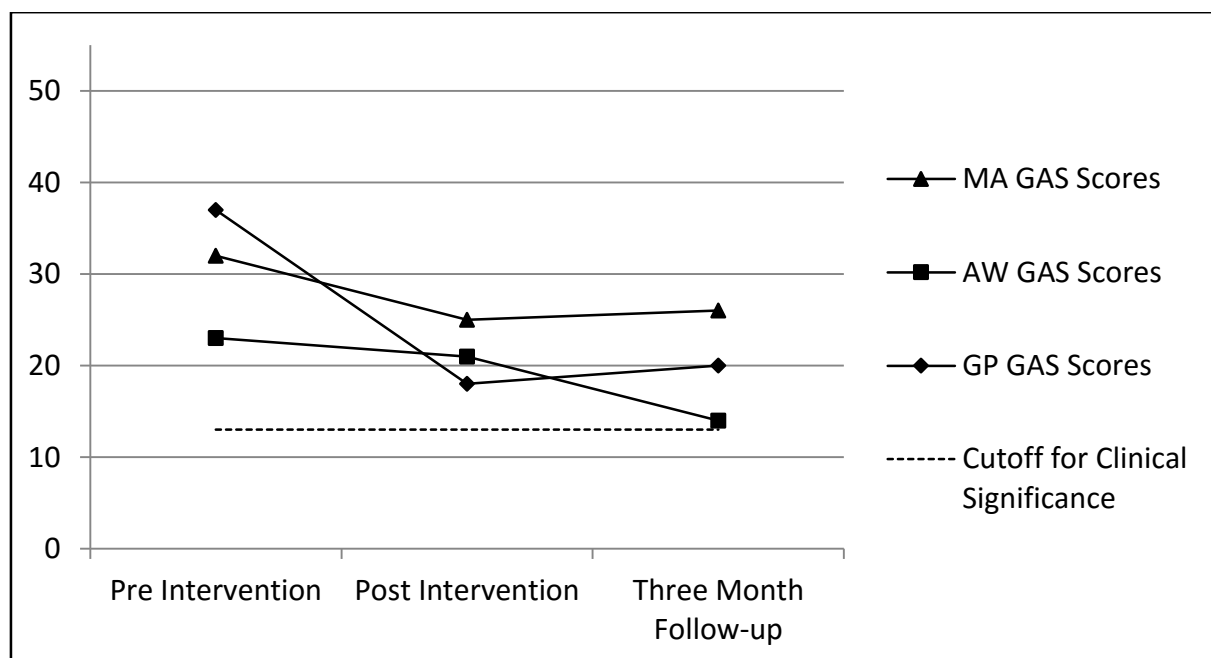


Figure 4.3. Overall Glasgow Anxiety Scale Scores.

With regards to depression as measured by scores on the GDS, all three participants' scores reduced significantly pre-post and remained significantly lower than at outset at three month follow up (table 4.4). In two cases, scores were clinically significant pre-intervention and in both cases they were not clinically significant post-intervention or at three month

follow up. In the third case (GP), the score pre-intervention didn't quite achieve clinical significance.

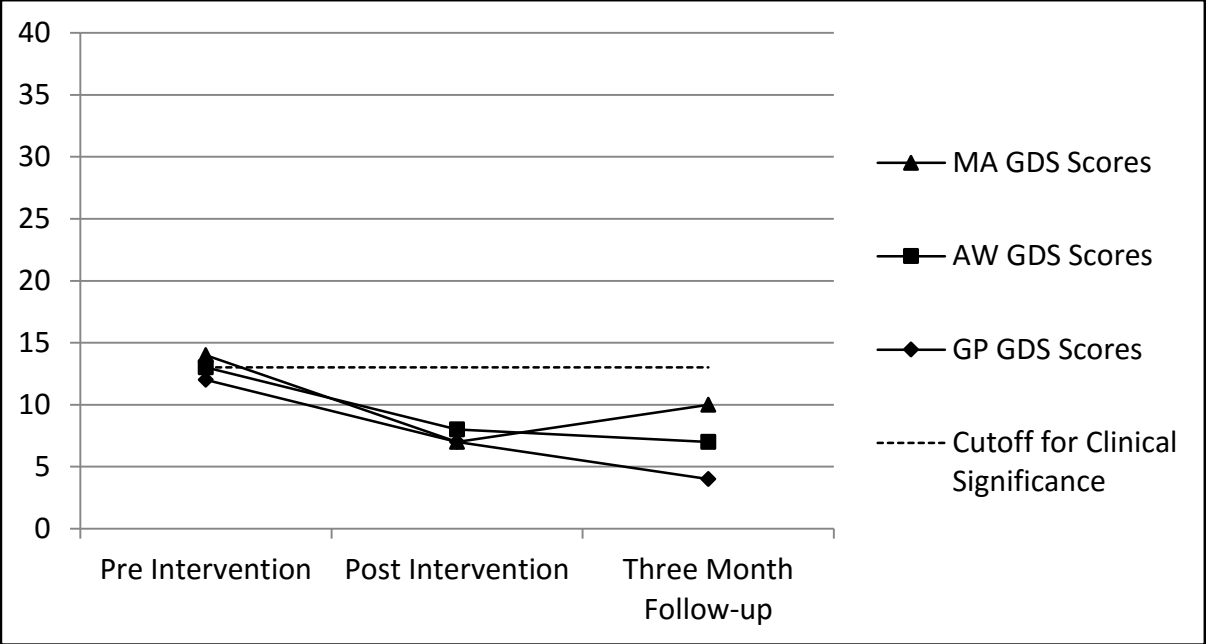


Figure 4.4. Overall Glasgow Depression Scale Scores.

Table 4.3. Glasgow Anxiety Scale and Glasgow Depression Scale Scores.

| | Glasgow Anxiety Scale (GAS) | | | Glasgow Depression Scale (GDS) | | |
|----|-----------------------------|-------------------|-----------------------|--------------------------------|-------------------|-----------------------|
| | Pre-Intervention | Post-Intervention | Three Month Follow Up | Pre-Intervention | Post-Intervention | Three Month Follow Up |
| MA | 32 | 25 | 26 | 14 | 7 | 10 |
| AW | 23 | 21 | 14 | 13 | 8 | 7 |
| GP | 37 | 18 | 20 | 12 | 7 | 4 |

Note 1: The clinical cut-off for diagnosis on both scales is 13. A score of 13 or greater is considered diagnostically significant

Table 4.4. Glasgow Anxiety Scale and Glasgow Depression Scale Score Changes.

| Participant | Glasgow Anxiety Scale (GAS) | | Glasgow Depression Scale (GDS) | |
|-------------|-----------------------------|-----------------------------|--------------------------------|-----------------------------|
| | Pre-Post | Pre - Three Month Follow | Pre-Post | Pre - Three Month Follow |
| | | Up | | Up |
| MA | -7 | -6 | -7 | -4 |
| AW | -2 | -9 | -5 | -6 |
| GP | -19 | -17 | -5 | -8 |

Note 1: The clinical cutoff for diagnosis on both scales is 13. A score of 13 or greater is considered diagnostically significant.

Note 2: A score change of three points or more on the GAS or two points or more on the GDS is considered statistically significant.

Table 3.4 describes the range of possible outcomes for clinical and significant change, these are applied to the data set in tables 4.3 and 4.4.

Table 4.5. Descriptive Outcomes for all Participants, Pre intervention to Post intervention.

| Measure | MA | AW | GP |
|-------------------------------|-------------------------|-------------------------|-------------------------|
| Overall Self-Compassion (SCS) | No change | Significant Improvement | Significant Improvement |
| Anxiety (GAS) | Improved, not recovered | No Change | Improved, not recovered |
| Depression (GDS) | Recovered | Recovered | Not Depressed at outset |

Table 4.6. Descriptive Outcomes for all Participants, Pre- Three Month Follow Up.

| Measure | MA | AW | GP |
|-------------------------------|-------------------------|-------------------------|-------------------------|
| Overall Self-Compassion (SCS) | No change | Significant Improvement | Significant Improvement |
| Anxiety (GAS) | Improved, not recovered | Improved, not recovered | Improved, not recovered |
| Depression (GDS) | Recovered | Recovered | Not Depressed at outset |

In summary, overall self-compassion scores have clearly improved for two participants (GP and AW) but there was no significant improvement for the third participant (MA). All three participants reported significant reductions in anxiety, but remain above the clinical cut-off for diagnosis. Two participants were depressed at outset but were no longer depressed post intervention, the third was on the brink of diagnosis at outset but not so post-intervention.

4.5 Data Synthesis

Data Synthesis follows the recommendations of Cresswell and Plano Clark (2011, pp. 203-250), especially regarding the presentation of convergent and divergent data for each emergent inference. The analysis was treated as a parallel design (Teddlie & Tashakkori, 2009, pp. 266-269) although it could also have been treated as a case –oriented design (Cresswell & Plano Clark, 2011, p. 228). This means that each arm was fully analysed prior to any data synthesis taking place. By contrast in a case-oriented design, each participants' qualitative and quantitative data would have been individually merged prior to final synthesis of data across participants. This decision was taken as it allowed a more complete Interpretative Phenomenological Analysis to take place first, which was felt to be more likely to capture the key themes emerging from the qualitative data. Individual qualitative case

analysis may not have enabled some of these themes to emerge to the same extent.

Additionally, the broadly homogenous outcomes achieved suggested that a shared understanding of the experience may be possible.

Inferences are presented as a summary table (table 4.7); below the table each inference is further elaborated.

Table 4.7. Summary Table of Mixed Methods Inferences.

| Inference | Convergent Evidence | Divergent Evidence |
|-------------------------------|---|--|
| Participant Anxiety Decreased | <p>Two participants reported statistically significant reductions in anxiety post intervention.</p> <p>All three participants reported statistically significant reductions in anxiety at three month follow up.</p> <p>Categorical Change:</p> <p><i>'Uh just being like normal kind of thing'</i></p> | <p>No clinically significant reductions in anxiety were reported, all three participants remain clinically anxious.</p> <p>Ongoing Learned Helplessness:</p> <p><i>'Um sort of doing everything she told me to do'</i></p> |

The Faulty Self

Glasgow Anxiety Scale decreases at follow-up

for each participant equate to 1.71, 2.56 and
4.84 standard deviations

I was different:

*'I just felt different kind of thing like I was
stupid from everyone else...'*

Becoming Normal:

*'Um we can all do things the same kind of
thing and no-ones different '*

Mixed Impact on Overall Self-Compassion

No significant change in SCS scores for MA.

For GP and AW, SCS change was significant
post-intervention and at follow up

No awareness of Self-Compassion Concept in
interviews:

*'...she was beginning to think about self-
compassion how did she describe all of that
to you?*

Um can't remember...'

Increased Sense of Common Humanity

Becoming Normal:

'Um we can all do things the same kind of thing and no-ones different '

Common Humanity scores improved at follow-up for all three participants.

Isolation scores improved for two participants.

Ongoing Protective Shell:

'Imaginating like a shell kind of thing that you talk to kind of things like that helped yeah'

Slight deterioration in Common Humanity Score for one participant post-intervention

Isolation score deteriorated for one participant post-intervention and at follow up

Mindful Distraction Techniques

Mindfulness and Over-Identification scores

MA may have used the exercises daily:

showed no clear pattern of change for any
participant.

'Uh that that help me.

*Right so when do you use this how when do
you when do you look at that.*

Meditations Used to Manage Acute Distress:

Err like um morning times.'

*'take me teeth out she normally say take five
deep breaths and take them out and that's
been a lot better'*

4.5.1 Inference One: Participant Anxiety Decreased

All three participants reported statistically significant reductions in anxiety at follow up, indeed there was some evidence suggesting their anxiety continued to reduce post-intervention. The reduction in anxiety appeared to be significant enough for them to experience it as a categorical rather than dimensional change.

However, all three participants remain in the clinical range of anxiety. Possibly this is related to issues of learned helplessness, feeling that their wellbeing and life choices are dependent on others rather than themselves.

Overall, whilst each participant does have ongoing issues with anxiety, it seems reasonable to state that their anxiety has become less intense and debilitating during the period of the intervention.

4.5.2 Inference Two: The Faulty Self

There is evidence to suggest that participants felt a sense of difference from others pre-intervention, so powerfully captured in GP's statement *'I just felt different kind of thing like I was stupid from everyone else...'*

Post intervention, all three participants reported significant reductions in anxiety, which they appear to have experienced as categorical state changes. Given that they appeared to feel that the anxiety was originally a part of themselves, as opposed to them feeling that they were 'normal' but suffering from anxiety, it points towards a state change away from being 'faulty' at the level of the self.

4.5.3. Inference Three: Mixed Impact on Overall Self-Compassion

There were no significant changes in score for overall self-compassion for one participant. For two participants, scores improved post-intervention and at follow-up. However, there was almost no mention of self-compassion in the interviews. In fact, GP stated she had never heard of it.

Conceptually, self-compassion may be a complex idea for participants to understand. Although mixed evidence for change emerged through the use of questionnaires and interviews, this does not preclude the possibility that change has taken place which may not have been captured by the tools used.

4.5.4. Inference Four: Increased Sense of Common Humanity

Participants described the experience of becoming normal, like everyone else rather than separate from and different to others. This change is also echoed in Common Humanity and Isolation scores on the SCS. All three participants showed improvement in their common humanity scores at follow-up. Two participants showed improvement in isolation scores post-intervention and at follow-up.

However, one participant (GP) suggested that there may still be limits to the extent to which she feels safe around others. She described creating an imaginary shell when talking to others rather than perhaps fully engaging with the person. Additionally, one participant reported a slight reduction in common humanity scores post-intervention but did subsequently report an increase at follow-up. Possibly this is just natural variation in the scoring or may reflect growing insight into the limited extent to which she had previously

experienced a sense of common humanity. The same participant also reported deteriorating scores for Isolation at both post-intervention and follow-up, though again there was improvement between these two time points.

Therefore, the balance of evidence may suggest an improvement in participants' sense of common humanity although there is some divergent evidence to suggest otherwise, or at least that the picture is quite complex.

4.5.5. Inference Five: Mindful Distraction Techniques

There was no clear direction of change for either mindfulness or over-identification scores at either time point. Additionally, where GP & AW discuss mindfulness, they do so entirely within the context of using exercises to manage acute episodes of distress.

By contrast, MA appears to suggest that he engages in regular exercises, though his account is somewhat unclear on this point.

On balance, there is no clear evidence to suggest that participants have developed effective and easily recalled regular mindfulness practices. However, they may have learned to use mindful breathing (and perhaps compassionate imagery) as effective interventions to help manage short term distress.

Chapter 5. Discussion

5.1 Summary Findings

In this chapter, inferences have been clustered into two larger groups. The first group brings together the reduction in participant anxiety with the faulty self. The second considers the various inferences related to self-compassion; that there was limited evidence for change in overall self-compassion; mindfulness appears to have been understood as an intervention to use when distressed and participants appeared to experience an increase in their sense of common humanity.

5.2 Anxiety and the Faulty Self

Participants reported significant reductions in anxiety, which they appeared to understand as a form of categorical change in the self. Whilst the evidence from this study is only correlational, this change can be seen positively. The reduction in anxiety offers support to Welford's (2010) argument that CFT can be of value with people with anxiety and is similar to Boersma's (2014) findings of mixed positive results in a non-clinical population of undergraduates with social phobia symptoms.

However, despite the degree to which their anxiety reduced, all three participants remained clinically anxious, possibly as a consequence of their high levels of initial anxiety. This differs from the findings of Gilbert & Proctor (2006) who report reductions to non-clinical levels in their population of people accessing a mental health day centre. The difference raises issues regarding case identification and the extent to which people with learning disabilities may need to demonstrate symptoms of anxiety before they are identified and referred for psychotherapy. It may also reflect issues of diagnostic overshadowing, where behaviours

which in others might be attributed to anxiety, are instead attributed to the presence of a learning disability, delaying the point at which people might be referred for treatment. In any event, the high levels of anxiety present at outset are notable and may have impacted on the outcome of the study. For the most part, gains made were maintained at three month follow-up, as was the case for Ashworth et al. (2014) in their study of people with ABI and as described by Lawrence & Lee (2013).

Participants appear to have understood their reduction in anxiety as a categorical change in self-hood. Perhaps for them, self and anxiety were mutually connected at outset so when the anxiety was significantly diminished, their sense of selfhood changed. Ashworth's (2014) participants also reported a revaluing of the self, whilst Lawrence & Lee's (2013) participants described wondering '*who am I if not self-critical?*'. There may be a consistent theme across these studies connecting changes in self-compassion with changes in self.

In accepting an understanding of categorical change in the self, I have pragmatically adopted a positive, achievement oriented perspective towards participants' statements. Generally, categorical thinking can be more common than dimensional thinking in people with LD, perhaps reflecting their relatively more limited cognitive abilities. Perhaps alternatively the categorical shift in their thinking could be described as a consequence of impaired cognitive resources. Doing so might be 'less useful' (Cornish & Gillespie, 2009) in furthering the cause of providing high quality therapeutic care to people with learning disabilities and anxiety. This therefore represents a moment where epistemology directly guided theme selection.

As well as thinking about participants' ongoing anxiety in terms of the high level of anxiety they exhibited at outset, it can also be thought of in terms of their narratives of learned helplessness (Seligman, 1972) and externalisation. If participants continue to feel that their

lives are subject to the whims of outside forces and that they possess only limited personal agency, then it may be no surprise that they continue to see the world around them as an anxiety inducing environment. Ashworth's (2014) participants described a similar experience of an unsafe world though they were not diagnosed with social anxiety.

Maybe a limitation of the CFT model is that it does not directly address issues of personal agency. Perhaps a more conventional CBT approach might have been more able to support participants to learn that they can have personal agency in their lives and thereby reduce some of their sense of learned helplessness.

Reflections – Whilst other themes could have emerged, those that did do so feel familiar to me. I have already acknowledged the role of a pragmatic approach to theme selection. However, perhaps I also have to acknowledge the extent to which my own fore-knowledge and desire to promote social justice has helped co-create these findings. If I was less familiar with working with people with learning disabilities, might I have chosen to highlight different issues, such as their possible difficulties with dimensional thinking?

5.3 Self-Compassion, Mindfulness and Common Humanity

For these participants, there was limited evidence for increases in overall self-compassion, mindfulness appears to have been understood as an intervention to use when distressed and they appeared to experience an increase in their sense of common humanity.

The self-compassion scale indicated significant changes in two out of the three participants' sense of self-compassion. Werner et al. (2012) argued that self-compassion would be lower in people with social anxiety, and that interventions aimed at improving self-compassion

might alleviate symptoms of anxiety. The evidence from this study is unclear regarding correlations between self-compassion change and social anxiety change.

Discussion of self-compassion was largely absent from all of their narratives and was mostly re-interpreted into ideas such as not hurting themselves, echoing some of the findings of Neff, Pisitsungkagarn & Hsieh (2008). Conceptually, it's possible that the concept of self-compassion and the questions in the SCS may be too complex for people with learning disabilities to engage with. This finding differs from that of Pauley & McPherson (2010) who reported that participants drawn from adult mental health clinical caseloads understood self-compassion. It may though support Werner et al.'s (2012) report that they were unable to show a correlation between self-compassion and social anxiety in their cross sectional study.

This does not preclude the possibility that participants' self-compassion has changed in ways that may not be captured either through interview or the SCS. Either participants may lack awareness of the changes, or those changes may have been conceptualised in ways that were not previously described in the existing literature. Gilbert (2009) argued that self-compassion can be conceptually difficult to grasp for people with limited experience of emotional warmth. Perhaps for these participants an overall grasp of self-compassion and the ability to express it may have eluded them. For example, the comment from AW suggesting she understands self-compassion as not hurting herself hints at a new and idiosyncratic way of understanding self-compassion and differs from Pauley & McPherson's (2010) findings.

Participants report using mindful breathing as an intervention when distressed, but not as regular practice. The CFT model promotes regular mindful practice and the SCS measures

mindfulness as one of its key subscales. Mindfulness has been recommended for people with learning disabilities for some time (Chapman, et al., 2013) and regular mindful practice is central to CFT (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006; Jazaieri, et al., 2013). It is therefore surprising not to find evidence of change in mindfulness, although Lo (2014) does point out how difficult self-compassion practice can be for people.

Perhaps the longer term benefits of mindfulness have not been identified by the SCS or recognised by participants. Specific mindfulness scales exist, perhaps they might demonstrate improved sensitivity to change in this population. Alternatively, maybe the need for regular practice and recognition of the benefits of practice has been lost in the complexity of a CFT intervention in which mindfulness represents only one aspect. Lucre & Corten (2013) recommend an increased focus on behavioural interventions, which might be how mindful breathing has been understood by these participants. Alternatively, maybe a greater emphasis on mindful practice within the therapy may have promoted more regular mindful practice between sessions.

Participants did report an improvement in their sense of common humanity, in contrast to Pauley & McPherson's (2010) finding that participants linked compassion mainly with kindness and forgiveness. This is more in keeping with Ashworth et al.'s (2014) finding that participants initially saw an unsafe world, then developed new relationships with others during therapy; also with Lawrence and Lee's (2013) finding that participants no longer felt alone in their struggles, and with Lucre & Corten's (2013) finding of improvements in social comparison amongst participants with personality disorder.

All three participants described social anxiety as their presenting difficulty and perhaps it is no surprise to find that after treatment they feel less separate and more connected to the

social world around them. Had they presented with less social forms of anxiety, maybe this finding might not have emerged to the same extent.

Finally, it's also noteworthy that there was no evidence of self-directed hatred from participants as was found by Ashworth et al. (2014) in their sample with ABI.

Whilst the findings regarding anxiety felt familiar and perhaps expected to me, these findings were more unexpected. Whilst I'm surprised by the limited understanding of mindfulness reported by participants, the positive side of this is that I feel more reassured about the balance of client: researcher co-creation of findings. These findings certainly didn't principally emerge from my own fore-knowledge of the topic.

5.4 Connections with the Wider Research Literature

Several other studies have also explored participants' experience of CFT. Participants have included people with a diagnosis of personality disorder (Lucre & Corten, 2013), people on an acute inpatient unit (Heriot-Maitland et al., 2014), people with acquired brain injury (Ashworth et al., 2015) and those who have experienced trauma (Lawrence and Lee, 2013).

A number of themes emerging from this study are similar to ones emerging from these other studies. In three cases, the issues discussed next are inferences drawn across both arms of the study. In the final case the theme emerged solely from the qualitative data arm but is considered significantly theoretically important to have been included at this stage of the discussion.

Inference Two: The Faulty Self

This inference appears similar to themes emerging in Ashworth as well as Lawrence & Lee's papers. Ashworth's participants described self-critical thinking pre-intervention, particularly through the use of aggressive and image-inducing negative language. Lawrence & Lee's participants described how at the start of therapy they felt they didn't deserve self-compassion and wanted to reject it as hopeless. Perhaps all three sets of participants are reporting that before therapy they felt different or faulty; deserving of self-critical thinking or undeserving of self-compassion or '*stupid from everyone else*'.

When change has occurred, many of the same participants may have understood it as categorical rather than continuous. Lawrence & Lee's participants faced '*the battle to give up the inner critic: who am I if not self-critical?*'. Within this research I have described the sense of a significant change of selfhood. This may mirror the need to find a new identity that Lawrence & Lee's participants appear to have experienced. Ashworth et al.'s participants also appeared to be wrestling with issues of categorical vs dimensional change, with some seeing their difficulties as continuing into the future in a reduced manner but others feeling they have made a break from the past and now have a different experience of life.

Inference Three: Mixed Impact on Overall Self-Compassion

Some participants describe finding self-compassion to be an alien and frightening experience and something they did not feel they deserved (Lawrence & Lee 2013). Others describe it as something to be feared (Lucre & Corten 2013). By contrast, other participants report finding self-compassion to be interesting or of value in their lives. Ashworth et al.'s (2015) participants described the impact of CFT on their lives and how it has given them a

new way to relate to themselves. However, they did not appear to directly describe CFT practice or make sense of their new experiences in terms of the CFT model. Heriot-Maitland et al. (2014) also report their participants appreciating learning about self-compassion. The varied nature of these findings might be consistent with the findings from this study of only a mixed impact on overall self-compassion. As discussed later, there are ongoing debates about the role of therapeutic models verses common factors approaches to understanding change. Maybe this theme can be understood as suggesting that specific factors related to CFT where not always the most memorable aspects of client's experiences of therapy.

Inference Four: Increased Sense of Common Humanity

Lawrence and Lee's (2013) participants describe learning that they are not alone in their struggles whilst Heriot-Maitland's (2014) report a strong sense of common humanity and affiliative bonding post-intervention. Lucre and Corten's (2013) CFT group also commented on the comfort of shared group experiences. An increased sense of common humanity was also evident across both arms of this study. Maybe an increased sense of common humanity is actually a common outcome of CFT, not just in people with socially oriented anxiety difficulties.

Subordinate Theme: The Therapist Helped

Ashworth et al.'s (2015) participants describe appreciating the consistent caregiving they experienced from their care teams. In particular, they describe their therapist as a primary source of care and comfort. Lawrence and Lee (2013) also report that their participants valued the importance of the therapeutic relationship. They saw their therapists as being kind and empathic human beings and a source of guidance.

Participants in this study saw the therapist as helpful. Participants across all three studies appear to be commenting on the value to them of aspects of their relationship with their therapist.

It is also noticeable that Inference Five: Mindful Distraction Techniques does not appear in other published research into participant experience of CFT. As discussed in section 5.3, this inference may be related to the complexity of the model for people with learning disabilities to understand in the time available. Possibly, other populations of participants might not have encountered the same difficulties with this component of the model, or with the range of components included in the model.

In summary, there appear to be some broad similarities between themes emerging from this research and those already published regarding client experience of CFT. The absence of a consistent theme within the published research relating to an overall understanding of the concept of self-compassion is also noticeable. Instead, findings appear to be related to selected aspects of the CFT model as well as to participants' experience of change and of their relationship with their therapist.

This last point may highlight the role of the relationship between client and therapist in therapeutic change, irrespective of the therapeutic model being used (Wampold, 2010; Clarkson, 2003). Whilst the therapeutic relationship might not always be seen as central to writing about CFT, Gilbert (2007a) has written about it from this perspective. He conceptualises the therapeutic relationship as being composed of a number of elements (distress sensitivity, sympathy, distress tolerance, empathy, non-judgement) oriented around compassion and delivered within a general environment of therapist warmth. This conceptualisation does not appear well placed to capture the sense in which participants in

this study saw the therapist as a source of support. However it may help understand the separate qualitative theme: The Therapist's Compassion.

Whilst from a CFT perspective, the therapeutic relationship might be described as a necessary but not sufficient condition for change, Jones (2013) takes a different position with regards to work with people with learning disabilities. They interviewed counselling psychologists in the United Kingdom who work with people with learning disabilities and argue that the therapeutic relationship is fundamental to therapy and that its value can transcend therapeutic theory.

Jones' work can be positioned alongside broader conceptualisations of the therapeutic relationship. Martin et al. (2000) conceptualise the therapeutic relationship as '*the collaborative and affective bond between therapist and client*'. McElvaney and Timulak (2013) also examined the role of the therapeutic relationship in general adult mental health primary care. They report that one of the most helpful factors in 'good outcome' therapy was the clients' perception of being supported during therapy. However, they also report that when clients value the therapist's guidance, then this was more often associated with poor therapeutic outcomes than with good ones. Perhaps they are highlighting that when clients perceive their therapists as being the agents of change in their lives then therapeutic outcomes can sometimes be less positive. Similarly, from the perspective of the therapist, Jones (2013) highlights the tensions existing in working with people with learning disabilities between being client-led and being directive. The collaborative/ directive aspect of these conceptualisations might begin to offer a better position from which to evaluate the theme of 'The Therapist Helped'. In this sense, the therapist appears to have been seen as someone who has helped and offered advice and therefore has perhaps been understood as being

agentic in participants' lives. It is therefore notable that despite this apparent attribution of agency to their therapist, outcomes in this study appear to have been positive for participants and may again remind us of the pervasive sense of learned helplessness so often present in people with learning disabilities.

There is a well-established body of evidence suggesting that they are able to engage with a wide range of modern therapeutic approaches. These include Cognitive Behavioural Therapy (Kroese et al. 1997), Cognitive Analytic Therapy (Lloyd, 2013), Systemic Therapy (Baum & Lynggaard, 2006), Psychodynamic (Hodges, 2003) and Psychoanalytic (Sinason, 2010) approaches. Seen within this broader context, perhaps the importance of the therapist's perceived help can be seen as further support for common factors approaches to therapy (Wampold 2010, Clarkson 2003). Models such as the trans-theoretical model offered by Clarkson (2003) may be well placed to help conceptualise and understand the experience of these participants. Within this model, Clarkson offers an integrative therapeutic framework oriented around five components of the therapeutic relationship (working alliance, the transferential/ countertransferential relationship, the reparative or developmentally needed relationship, the person to person relationship and the transpersonal relationship) (Clarkson, 2003).

From Clarkson's perspective, participants' descriptions of 'The therapist as helpful' may reflect their experience of being engaged in an effective working alliance with their therapist. The associated learned helplessness which has already been discussed might then be understood within the context of a transferential or reparative relationship in which participants might be adopting a child role while projecting onto their therapist a parenting/ rescuing role.

In summary, perhaps the most important point to take from this discussion is that people with learning disabilities should not be excluded from accessing modern therapeutic modalities because they are perceived as not being able to benefit from them. The evidence from this study is that they may be just as capable of benefitting from them as anyone else.

5.5 Clinical Practice Implications

Qualitative and quantitative data appeared to triangulate regarding participants' experience of reducing anxiety. Although this finding appears to differ from Cooper et al.'s (2007) finding of higher rates of mental ill-health in people with LD when assessed by clinical judgement, it has potential implications for the measurement of anxiety in people with learning disabilities, suggesting that either clinical interviews or measures may be equally capable of evaluating respondent anxiety. Given the possible issues with case identification already discussed, maybe more regular use of mood screening measures could be considered in future to improve case identification.

The concept of self-compassion has proved difficult to measure and may have been rather too complex for participants to understand in its entirety. However, the therapist reports that she found the CFT model helpful in her work with participants. Perhaps change has taken place but not in ways that participants are consciously aware of or able to express. Whilst it can be common in clinical practice for people to not recognise the changes that have taken place for them, for people with learning disabilities this can be almost normal. As such, the question of whether the CFT model helped these participants remains open and in need of further research. Complicating this picture is the common factors argument in therapy research (Wampold, 2010) which suggests that the primary agent for change is less

the therapeutic model but rather factors common to all models such as the therapeutic relationship.

Issues of agency have arisen in these findings, in particular the participants' attribution of agency for change to the therapist (see section 4.3.2.1). This study design can only offer correlational evidence regarding such issues and it is therefore not possible to consider the extent to which the therapist may have been agentic in any changes, or indeed whether such changes might even been related to having undertaken therapy.

However, we can consider the implications of participants' perception that the therapist was agentic in their recovery. This is discussed elsewhere in the context of learned helplessness (Seligman, 1972) {Section 5.2}. It can also be considered in the context of locus of control (Rotter, 1966). Locus of control describes the extent to which we might attribute agency to factors which are internal or external to ourselves. Participants in this study appear to be attributing agency for change to external factors (the therapist) more so than to their own agency.

Recognising the extent to which participants appear to have a sense of learned helplessness and external locus of control has implications for service planning and delivery. National strategic planning for learning disability services is driven by several pieces of legislation and government policy centered around the strategy document; 'Valuing People Now: A new three year strategy for people with learning disabilities' (Department of Health, 2009) which sets out four key principles for the care and support of people with learning disabilities – Rights, Independence, Choice and Inclusion. These are operationalised as a focus on personalisation of care (ibid.), in which the needs and wishes of the individual should be placed at the heart of the care and support provided for them.

These findings today may highlight the need for people with learning disabilities to be supported not just to be offered choice and change, in keeping with 'Valuing People Now' but also to learn that they have agency to make such choices in their lives. The findings may also highlight the need for support staff and families to be supported to stop making choices on behalf of people they are supporting and allow them the opportunity to make choices for themselves.

Learned helplessness and attributing agency for change to external factors may not be attitudes that may be easily changed through the direct provision of psychological therapy if it is not also accompanied by opportunities in peoples' daily lives to practice exercising choice. Indeed, assuming that a therapist can help make someone more able to exercise choice in their life is itself externalising the agency for that very change to the therapist rather than the individual. Perhaps a key role for psychology is to support care providers and families in developing environments in which people with learning disabilities are routinely offered opportunities to learn to make decisions for themselves. Over time, repeated exposure to opportunities to make important choices in their lives may be more effective in overcoming a lifetime of disempowering experiences and attitudes than the provision of any short term psychotherapy. Such an approach would be completely in keeping the ethos of 'Valuing People Now'.

During training my personal position has shifted considerably towards a relationally led understanding of therapy. As such, I believe that change took place due to the quality of therapeutic encounter offered by the therapist. Perhaps the role of CFT has been to support the therapist in offering this relationship. From the therapist's perspective it seems that the

model may have been useful, though the evidence is more complex from participant reports. Perhaps it's in this context as a tool to support the client-therapist relationship that CFT may be of use in future.

However, the model has a number of elements to it and perhaps it has proved to be too complex to use in its entirety with people with LD. Utilising the overall framework and selected elements of the methodology may be the way to go in future.

5.6 Research Methodology and Epistemology

5.6.1 Homogeneity

Participants met the criteria for homogeneity laid out by Nezu & Nezu (1994). However, there are noticeable differences in their experience of and response to CFT. It is possible that at least some of these differences may be mediated by the relatively better cognitive ability of one participant (GP) compared to the other two. Whilst such issues are likely to arise in all research populations, it raises questions about the degree of heterogeneity likely to be present in small group research with people with learning disabilities. In clinical practice, it's understood that there can be considerable variation between individuals' cognitive difficulties, even when their superficial level of functioning may appear similar. In small group research and case study designs these individual differences may be more of an issue than in large-n studies given the greater impact any one participant may have on the research. Perhaps it needs to be more clearly accepted that small groups of research participants with learning disabilities are likely to be more heterogeneous than might be the case with participants from other population groups.

5.6.2 Practical Mixed Methods Issues

One issue that arose in the analysis was the question of when the data from the two arms should be merged. The plan (which was adhered to) was to complete the analysis of the qualitative data and to separately complete the analysis of the quantitative data, then to merge the two together. Merging the data at this point raised issues regarding the within participant nature of the quantitative data and the across participant nature of the completed IPA analysis data. At outset, I had considered the possibility of merging quantitative and qualitative data for each individual participant before combining data across participants. This would have permitted the merging of two types of within participant data before combining them to produce across participant overall results. However, doing so might have led to more fragmented final qualitative data. Perhaps arguments could be made for either approach to data synthesis, this issue should be considered in advance in future similar mixed methods research.

Using mixed methods in a professional doctorate research study and thesis creates particular resource issues. The amount of time available for the study and the word count limitations of the thesis limit the extent to which data analysis for each arm can be as thorough as might be the case in a purely quantitative or qualitative study. A larger sample size might have been useful in both arms, but analysing and reporting much more data might have overwhelmed the resources available (especially therapist time) and might have been difficult to report within the available word count. In order to use mixed methods in a resource limited report, compromises were necessary in both arms. Some rich data was left behind in both arms during data synthesis. If mixed methods are to be used in this type of project in future then these resource implications should perhaps be more carefully

considered at outset. However, the richness and triangulation of data possible with mixed methods does appear to justify its use in this case.

5.6.3 Language, Data Interrogation and Hermeneutics in LD Research

Smith, Flowers and Larkin (2009, p. 104) describe how an IPA researcher might analyse metaphors present in an interview transcript. They use an example of a participant comparing themselves to a horse. In working with people with learning disabilities, the desire to analyse to this level must be tempered with the realisation that participants may not be drawing from the same rich pool of potential metaphors as other potential participants. Analysing the metaphor of self as a horse assumes that the participant chose the horse from a large pool of possible animal metaphors, each richly populated with different characteristics. However, if the participant only has a small pool of possible animals from which to draw and if each potential animal has only a limited number of potential unique characteristics then the metaphor must be interpreted with caution. For instance in this study two participants used a shell metaphor. Whilst I felt able to consider this as a metaphor for protection, I did consider the extent to which they may understand that metaphor themselves or perhaps be echoing something that someone else may have said to them.

IPA focusses strongly on hermeneutics (Smith, Flowers, & Larkin, 2009, pp. 21-29) and explicitly acknowledges the role of the interpreter of the text in making meaning from the material presented to them. This position allows space to acknowledge the impact of the researcher's own fore-knowledge in the interpretation. In this case, it allows me to acknowledge that I have interpreted the texts taking into account my clinical experience of working with people with learning disabilities. For instance, when thinking of participants'

use of metaphor, I was aware that people with learning disabilities may use seemingly common place words without fully understanding the semantic meaning of those words (we all do this, perhaps people with learning disabilities do it more often and with words it's easy for others to assume they fully understand).

Bearing this in mind, IPA permits the findings from interpreting transcripts of interviews with people with learning disabilities to be explicitly acknowledged as a co-production between participant and researcher. This is certainly the case with this project and justifies the decision to use IPA methodology in part to acknowledge this issue. However, it's also worth noting that the participants do appear to have been able to contribute meaningful qualitative data, as suggested by Lloyd, Gatherer & Kalsy (2006), Smith (2004) and Macdonald, Sinason & Hollins (2003).

A hermeneutic understanding of co-produced research findings needs to be balanced against an awareness of issues of data reliability and validity. In this case, findings have been mostly derived by combining qualitative and quantitative data to produce mixed methods findings. If we consider questionnaires and interviews to be two different methodologies for interrogating participant experience then we might understand their merging as a form of triangulation. Doing so is consistent with pragmatic epistemology.

When considering 'truthfulness', pragmatism focusses attention on the outcome of the study and suggests that if the findings have meaning and influence in the lives of participants then they can be considered as valid. Whilst this appeals from a social justice perspective and resolves some epistemological issues associated with mixed methods research, it is of only limited guidance during the data synthesis stage of the project.

However, it was helpful in guiding theme selection within the qualitative arm of the study. For example, it would have been possible to develop a theme regarding the limited ability of participants to engage in dimensional thinking instead of a theme about categorical change in the self. However, doing so would have focussed attention onto their inability rather than their experience of change. As such, it might have been less likely to fulfil my goal of improving the therapeutic experiences of people with learning disabilities. It is therefore 'more useful to believe' (Cherryholmes, 1992) that they experienced a categorical change in selfhood.

Regardless of epistemological stance, the blending of pre-post measures with post intervention interviews does seem to offer the potential for good ecological validity, perhaps being similar to the way that many clinicians would evaluate individual therapy through talking with the client and perhaps using pre-post measures. Perhaps it also allows the voices and experiences of participants to be heard through this project. The social justice implications of hearing unheard voices appealed to me from the outset and I'm pleased this aim appears to have been achieved.

I'm not sure where I now sit epistemologically with regards to mixed methods research. Pragmatism felt like the right choice at the outset and was supported by key mixed methods writers. However at the end of the project I feel like critical realism would have been a more helpful position when making decisions about data integration. Perhaps my personally more social constructionist beliefs hold me back from embracing any epistemology which posits the existence of a single reality for what I consider to be largely socially constructed issues.

5.7 Limitations of the Research

The Self-Compassion scale proved to be a limitation of this study. The language and possibly the underlying self-concept may have been too sophisticated for easy adaptation for this client group. Using the measure with these participants required more interpretation than had been anticipated and as a result findings from this measure must be interpreted with caution. In the event, key findings could be triangulated with qualitative data thereby providing additional validity. Nevertheless, the reliability and validity of the SCS when used with this client group seems to be significant limitation of the quantitative arm.

All pre-post and follow-up measures were taken just once. In a more comprehensive quantitative design it would have been ideal to take several consecutive measures at each time point rather than rely on single point estimates. This certainly is a limitation of the quantitative arm of the present study.

More generally, the ability of people with learning disabilities to verbally express their experiences can be more limited than that of the general population. This may have limited the extent to which participant accounts may be a fair representation of their experience.

Whilst it's valid to highlight these limitations, the fact remains that hearing participants' voices fulfils a social justice function and is compatible with the pragmatic epistemology adopted by the study. I would be keen to use the same methodological approach again.

This project adopted a case study design and had three participants. Its strength is in the depth to which their individual experiences were explored. Obviously the study cannot infer causation between therapy and reductions in anxiety. To the extent that it is ever possible to infer causation in therapeutic research, this could only be achieved via a large-n

randomised control trial. Whilst such a trial would be invaluable, the initial priority should probably investigate the use of CFT in a mainstream adult population.

5.8 Recommendations for Future Research

This project was always intended to be a first look at the use of CFT for people with learning disabilities and as such it was intended to pave the way for more research in the area.

Recommendations include:

Issues of power were present throughout the interviews. The use of a narrative technique such as Foucauldian Discourse Analysis (Willig, 2008, pp. 112-131) might allow issues of power to come to the fore and thereby highlight the ongoing issues of learned helplessness and power imbalances seemingly still present in the lives of these participants. Similarly, action research techniques (Koshy, Koshy, & Waterman, 2011) would be of value in continuing to respect the experiences of people with learning disabilities.

If further small-n studies with people with learning disabilities are conducted, then they might consider adopting similar mixed methods approaches to this research thereby enabling participant voices to be heard clearly. Such research will need to address at an early stage the questions of homogeneity, epistemology and data integration which have been discussed in relation to this project.

There are some specific research recommendations which emerge from the study findings. Chapman et al. (2013) conducted a systematic review and narrative analysis of the role of mindfulness in this population, staff and parents. They focussed their analysis on the impact of mindfulness training on target problems in participants. The largest participant study had 15 participants, one was a single case study. The mechanism of action of mindfulness is not

examined in their analysis and the authors call for research into this issue. Based on the findings from my own research which might suggest a limited function for mindfulness, I would now echo this call.

An exclusion criterion for this study was the presence of an autistic spectrum disorder (ASD). Conceptualisations of the self in someone with ASD may be more complex than in non-ASD populations (Toichi, et al., 2002), although no research has been conducted on this topic from a CFT perspective. This would be an interesting issue to follow-up.

As already discussed, the Self-Compassion Scale seemed to be overly complex for use with this group. It would need considerable adaptation and re-standardising if a useable version was to be created for this population group. This would be a significant piece of work to undertake. However, it may be that the underlying concept of self-compassion is the issue rather than the measure. Research in this area might start by establishing basic ways to have conversations with people with learning disabilities about self-compassion.

This research could potentially be generalised in at least two different directions. Firstly, the mixture of therapy and research methodologies could be applied to other samples, for instance general adult mental health clients. Doing so might generalise the understanding of CFT developed through this research across a range of different population groups. To promote the possibility of such research taking place, it is intended to attempt to publish these findings in a peer reviewed journal. Doing so may encourage future researchers to apply a similar mixed methods approach to CFT research with other populations.

Secondly, since this investigation consists of a small number of single case studies, it is not possible to generalise the findings to other clients with learning disabilities and anxiety, or to

suggest any cause-effect links. To be better able to do so, a large scale outcome study would be required. Such a study would need to consist of a randomised control trial, ideally multi-centre and multi-therapist. It would also need to have a protocol in place to evaluate treatment protocol compliance and would need to consider the points raised from this study regarding sample homogeneity and treatment methodology complexity. Consideration could still be given to collecting some qualitative process data within such a design (Goldfried and Eubank-Carter, 2004). Such a study would represent a substantial investment of resources and financing. Nevertheless since research remains a core task of the NHS and of counselling psychology, it is possible that such a study could be undertaken in future.

5.9 Closing Reflections

With regards to my experience of undertaking this research, there are a number of issues related to designing the project and then collecting and analysing the data which bear further reflection. These include how I negotiate the change in role between researcher and my day to day role of therapist. Also the impact that my experience in working therapeutically with people with learning disabilities may have had on my epistemological choices as well as on the outcomes of the research.

My epistemological choices were largely driven by current theoretical writing on mixed methods research (Teddle & Tashakkori, 2009; Creswell & Plano Clark, 2011). However it is also true that I was personally drawn towards a pragmatic epistemological position. This was largely because pragmatism understands 'truth' as 'useful to believe' while recognising that 'useful to believe' is an idea which can only exist within the context of the researchers own belief systems (see section 3.3 for further details). In this case, my relevant beliefs were

that I felt the need to be an advocate for the rights of people with learning disabilities to have access to high quality psychological therapy. The choice of epistemology might therefore be described as a convergence of theory with my own desire to express my beliefs throughout the research process.

Moving on to think specifically about the impact of my role in a learning disability service on this research, this project presented me with the challenge of deciding between adopting the role of therapist or researcher on several occasions. For instance, during qualitative interviews there were several occasions when participants discussed therapeutic issues. In these moments I was faced with a choice between following up on the therapeutic intervention, for instance by reinforcing a participant's compassionate understanding of an issue. Alternatively I could have held onto my identity as a researcher and explored their experience of that issue with them. These moments caused me to confront directly the researcher/ therapist dilemma that I have faced in this work and to make a choice about which aspect of my identity would be dominant in that moment. Fortunately there were no times when I felt that failing to follow up on the therapeutic issue would have a significant negative impact on the participant. Consequently I always felt able to remain mindfully in my role as a researcher.

Facing the dilemma of having to choose between being a researcher or a therapist led me to consider the dual role of therapists when researching therapy. Within this study, a number of steps have been taken to separate out these roles. These included handing over responsibility for participant identification and initial contact to the therapist working on the project rather than the researcher. Additionally, a protocol was drawn up (appendix 4) to regulate contact between researcher and therapist during the study. These arrangements were approved as

part of the NHS Research Ethics Approval process. The aim of these measures was to minimise dual role dilemmas whilst recognising that they could not be eliminated completely (McLeod, 2013). Issues of power inevitably remain present in the study, especially given the lifelong disempowering experiences of the client group. For example, given their limited sense of personal agency, learned helplessness and limited cognitive abilities, acquiescent responses to questions were always possible. Good practice when working with people with learning disabilities is to avoid leading questions and to ask questions in more than one way whenever possible. I routinely adopted this practice in all my contacts with participants. In practice, my experience of the researcher-participant power imbalance was that it was constantly in my mind in a way that perhaps it might not have been if I had been working with less obviously disempowered participants. Consequently when facing decisions about my dual role, I was always aware of the power imbalance between myself and the participant and to the best of my ability took this into account when making decisions about how to proceed (BPS, 2010).

Yanos & Ziedonis (2006) argue that awareness of such dilemmas remains insufficient unless they are also accompanied by an integration of clinician-researchers dual roles into a 'coherent morale identity' which then drives ethical decision making. A sense of moral identity does seem to capture my experience of these dilemmas between being a researcher and a clinician. I felt that I was being required to make a moral judgement balancing the conflicting demands of beneficence towards the research participant against scientific autonomy towards the study and the wider community (Pellegrino, 1992). I also needed to be aware that the most immediate beneficiary of a successful research outcome was myself in my role as a doctoral student looking to obtain good research data (McLeod, 2013) and

that I was therefore potentially at risk of being biased towards scientific autonomy at the expense of participant beneficence. I was mindfully aware of this potential issue throughout the research and made every effort to avoid it impacting on my decision making.

The ultimate question in this sense is whether clinicians should conduct research in the areas in which they work. It might be argued that an academic researcher might be better placed to conduct a study with good scientific autonomy. However, clinicians may be better placed to conduct research focussed on real-world issues that are relevant to themselves and their client groups (Yanos & Ziedonis, 2006). In this case, the absence of any existing research in the area highlights the need for clinicians to carry out research in areas where they perceive a need. In this instance, research supervision was provided by an academic psychologist, perhaps offering the best of both worlds.

When I consider what this might mean of my own ability to be a researcher in a learning disabilities environment, I remember that I consider myself to be an advocate for the rights of people with learning disabilities to have their voices heard and to be able to access high quality psychotherapy. Working from a pragmatic epistemology, I can view my skills that I have developed in working with people with learning disabilities as a positive. I am able to communicate effectively and believe that I was able to support participants to give a good account of their experience. Since these accounts have contributed to an understanding of their experience which may help give people with learning disabilities better access to therapy, I can argue that I have fulfilled the requirement for producing data which is 'useful to believe' and therefore can be considered 'truthful'.

On the other hand, it might be argued that my experience working with people with learning disabilities makes it harder for me to observe some aspects of the wider frame of therapy

with this group of people. For example, I am aware that working therapeutically with people with learning disabilities can be difficult and requires particular skills and adaptations. I take these reasonable adaptations largely for granted now and don't always consider them worthy of comment. It's possible that there are themes in the data or even entire topics that I chose not to ask about which might have seemed important to others who were less familiar with working with people with learning disabilities. For instance, perhaps they might have focussed more on topics such as the way in which the methodology was simplified and adapted to participants' cognitive difficulties. Doing so might have drawn attention to differences when working with people with learning disabilities rather than similarities, but might be no more or less meaningful ('truthful') than the results reported here.

There were several things I was able to do to help me reflect on these issues. The first was to make use of supervision. My academic supervisor is not a learning disabilities specialist and this proved to be very helpful as it prompted me to explain things that might have been taken for granted if they did also work in the field. Doing so caused me to reflect on some issues which I take for granted in my work. One example was related to the value of physically drawing the three elements of the emotion regulation system instead of simply verbally explaining them (helpful with people who might have limited verbal processing abilities). I did also have access to specialist learning disability psychology supervision through my clinical work. I used this supervision to run through early iterations of my qualitative themes and through it was challenged to think further about the mixed methods nature of my project. In particular I was challenged to think of mixed methods data synthesis as a form of data triangulation. Prior to this I had understood the process of synthesis as a final stage of analysis but hadn't really thought of it as a form of reliability checking.

Following this supervision I more clearly understood that being able to see the same finding emerging through different methodological lenses potentially allows for that finding to be considered more 'reliable'. Thinking this way allowed me to understand that I wasn't leaving behind data when I synthesised my findings so much as drawing out the data with the best chance of being considered reliable.

The iterative nature of developing my findings was a key element in my process which helped ground them into methodological theory. There were at least three distinct phases in my theme development when I re-examined the themes I had been developing and made substantial changes to them, or in some cases abandoned particular themes and developed new ones instead. In each case this occurred when during the act of writing one set of themes I was able to identify a new arrangement of themes which seemed to better capture the reported experience of participants. Whenever this happened, I initially returned to the methodological writing (in particular Smith, Flowers and Larkin's (2009) IPA handbook) and also read examples of peoples work in different fields. Doing so helped me hold onto my position as a researcher of participant experience and to move away from being a therapist reporting on the process of therapy. This process formed a substantial and difficult part of my analysis and was perhaps where I made most use of supervision to help me reflect on broader understandings of my findings. Deciding to start again on theme development after spending weeks developing them was always a difficult decision to make. I felt quite despairing at these points, as if the analysis would never end. Previous experiences of other large challenges in my life helped me remember that these sorts of feelings can be quite common in big projects and that all such things do end in time. Once I remembered this and after I had taken a short break from my data I was able to return to theme development and

writing up. I do think that the final themes are much stronger as a result of this process and also because of the re-engagement with theory that I went through between each iteration.

Taking into account all of the above issues, I finish this project feeling that the research methodology fulfilled my intention of allowing participant voices to be heard. My own voice is also present throughout these findings. In a hermeneutically understood manner, my voice calls out through the words and responses of the people I wanted this research to advocate for. For me, mixed methods now seems like a practical research methodology and one I'd use again. I also hope to see more mixed methods research published in this and other fields in future.

Chapter 6. References

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Chapter 7. Appendices

Appendix 1. NHS Ethics Favourable Opinion Letter



Health Research Authority

NRES Committee East of England - Cambridge Central

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839435
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02 April 2013

Mr Mark Hardiman
Trainee Counselling Psychologist
Norfolk Learning Disabilities Service
2nd Floor, Ferry House
South Denes Road
Great Yarmouth, Norfolk
NR30 3PR

Dear Mr Hardiman

| | |
|-------------------------|---|
| Study title: | A Mixed Methods Evaluation of the Experiences of Adults with Learning Disabilities and Anxiety Undertaking Compassion Focussed Therapy |
| REC reference: | 13/EE/0058 |
| Protocol number: | u1026969 |
| IRAS project ID: | 86534 |

Thank you for your letter of 21 March 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Jessica Parfremment, NRESCommittee.EastofEngland-CambridgeCentral@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|------------------------------------|---------|------------------|
| Covering Letter | | 31 January 2013 |
| Evidence of insurance or indemnity | | |
| GP/Consultant Information Sheets | 1 | 14 December 2011 |

| | | |
|--|------------------------|------------------|
| Interview Schedules/Topic Guides | 1.0 | 07 February 2013 |
| Investigator CV | | |
| Letter of invitation to participant | 1 | 08 August 2012 |
| Other: CV - Corrina Willmoth | | |
| Other: CV - Dr Kaposi | | |
| Other: CV - Dr Walsh | | |
| Other: Ethical Practice Checklist | | 17 December 2012 |
| Other: Researcher Risk Assessment | | 17 December 2012 |
| Other: Self compassion scale response chart | | |
| Other: Marking Criteria for the Doctoral Research Proposal | | 26 January 2009 |
| Other: Participant Process Flowchart | | |
| Participant Consent Form | 3 | 21 March 2013 |
| Participant Information Sheet | 5 | 21 March 2013 |
| Protocol | 3 | 09 January 2013 |
| Questionnaire: Sel Compassion Scale | 1 | 17 July 2012 |
| REC application | 86534/41566 9/1/347 | 30 January 2013 |
| Response to Request for Further Information | | 21 March 2013 |

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/EE/0058

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Mrs Carolyn Read
Chair

Email: NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr James J Walsh*
Ms Clare Symms, NHS Norfolk

**Appendix 2. Norfolk Community Health & Care NHS Trust Clinical
Governance Letter**

Ref: 2013LD01

Norfolk & Suffolk Primary Care Research Management Team

Hosted by South Norfolk CCG

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

Mr Mark Hardiman

Norfolk Learning Disabilities Service

2nd Floor, Ferry House

South Denes Road

Great Yarmouth

Norfolk

NR30 3PR

Tel: 01603 257283

Fax: 01603 257292

E-mail: paul.mills1@nhs.net

2 April 2013

Dear Mr Mark Hardiman

Re: 2013LD01 A Mixed Methods Evaluation of the Experiences of Adults with Learning Disabilities and Anxiety Undertaking Compassion Focussed Therapy.

REC Number: 13/EE/0058

Chief Investigator: Mr Mark Hardiman

Sponsor: University of East London

Further to your submission of the above project, this has now been reviewed by the Norfolk & Suffolk Primary Care Research Management Team on behalf of Norfolk Community Health & Care NHS Trust and all mandatory research governance checks have been satisfied. I am therefore pleased to inform you on behalf of **Norfolk Community Health & Care NHS Trust** that NHS permission (R&D approval) was granted on **2nd April 2013** for your study to take place at the following sites:

- Learning Difficulties Team, Norfolk Community Health & Care NHS Trust

You may now begin your study at the above sites. **Please note also, if you wish to extend approval to any sites other than those listed above you must apply for this separately.**

NHS Permission is granted on the basis of the information supplied in the application form, protocol and supporting documentation, if anything subsequently comes to light that would cast doubts upon, or alter in any material way, any information contained in the original application, or a later amendment application there may be implications for continued NHS Permission.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework and the terms of REC favourable opinion.

If you have any queries regarding this or any other project please contact Paul Mills, R&D Officer, at the above address. Please note, the reference number for this study is **2013LD01** and this should be quoted on all correspondence.

Chairman: Ken Applegate

Chief Executive: Michael Scott

Norfolk Community Health and Care NHS Trust Head Office: Elliot House, 130 Ber Street, Norwich, Norfolk NR1 3FR

The Norfolk & Suffolk Primary Care Research Management Team, hosted by South Norfolk CCG, undertakes research management, design and delivery services for primary and community care across Norfolk & Suffolk.

Yours sincerely

Dr Tracy Shalom
Head of R&D
Norfolk & Suffolk Primary Care Research Management Team
Hosted by South Norfolk Clinical Commissioning Group
Signed on behalf of Norfolk Community Health & Care NHS Trust

cc: Dr James Walsh, University of East London, Sponsor Representative
Dr David Kaposi, University of East London, Academic Supervisor
File

Conditions of NHS Permission

Please note the following conditions of NHS Permission - it is your responsibility to ensure that these conditions are disseminated to all parties involved in this project at the above sites.

You must notify the Norfolk & Suffolk Primary Care Research Management Team of:

- All proposed changes to this study, whether minor or substantial
- All Serious Adverse Events relevant to the above sites
- Any deviations from the protocol or protocol breaches including any urgent safety measures that are required to be taken in order to protect research participants against any immediate hazard to their health or safety
- All incidents¹ or complaints in relation to the research project at the above sites
- Any Sponsor or funder initiated audits, or any regulatory inspections to be conducted in relation to this study at the above sites
- The study conclusion and/or termination of the study; where smartcards have been issued, this notification must be made on a site by site basis to allow deactivation of smartcards at that site.
- All publications relating to the study

Documentation:

You are required to maintain a site file for the study at your site. This should be maintained in accordance with ICH-GCP and will include as a minimum:

- (a) Final approved protocol
- (b) Copies of REC favourable opinion, NHS Permission letter relevant to your site, any other approvals necessary (e.g. MHRA)
- (c) Participant information sheets, consent forms, invitation letters, posters/adverts and any other documentation given to the participant

It is your responsibility to update the information held at each site with any amendments made to this documentation and all approval letters applicable to those amendments and to ensure that all essential documents held at site are maintained, stored and archived as appropriate.

Transfer of data

- Transfer of patient identifiable or confidential data must be in accordance with Trust policies.

Scope of permission

- Please note that the above permission applies only to research activity on NHS staff or premises or involving NHS Patients and/or their tissues, data or samples. Separate agreements and permissions will be required for research involving private patients or those under the care of social services.

¹ An incident is defined as any event or circumstance that could have, or did, lead to harm, loss or damage and includes loss of data, confidentiality breaches, harm to researchers or staff or damage to property.

Documents Reviewed

The following documents were reviewed:

Letter of Favourable Opinion from NRES Committee East of England – Cambridge Central, dated 2nd April 2013

- Evidence of Insurance/Indemnity
- Letter to GP, Version 1, 14th December 2011
- Interview Schedule, Version 1, 7th February 2013
- Investigator CV – Mark Hardiman
- Investigator CV – Corrina Willmoth
- Investigator CV – James Walsh
- Investigator CV – David Kaposi
- Participant Invitation Letter, Version 1, 8th August 2012
- Participant Information Sheet, Version 5, 21st March 2013
- Participant Consent Form, Version 3, 21st March 2013
- Protocol, Version 3, 9th January 2013
- Questionnaire – Self Compassion Scale, Version 1, 17th July 2012
- Response to Request for Further Information, 21st March 2013

Other Documents Reviewed

- NHS R&D Application Form, Lock Code 86534/413899/14/291
- NHS SSI Form, Lock Code 86534/427723/6/185/119088/268135

**Appendix 3. University of East London, School of Psychology Ethics
Sub-Committee Letter**

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



**School of Psychology
Professional Doctorate Programmes**

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



Appendix 4. Researcher-Therapist Protocol

1. The clinical need of the client will always take priority over the needs of the research project. In the event that the therapist feels it necessary to deviate from the agreed research protocol, they are free to do so and the client will be withdrawn from research.
2. Normal clinical supervision arrangements will continue for the therapist. Participants will be discussed as needed in supervision.
3. The researcher and therapist will agree a detailed protocol for the intervention phase of the project, based on Gilbert's and Welford's key papers. This protocol will balance routine clinical discretion against dictating the overall approach to be adopted.
4. The therapist will locate potential cases from the team waiting list and make initial contact with them to complete a 'face value' eligibility assessment before passing over to the researcher for full consent and initial screening. Cases will be opportunistically selected, i.e. the next three potentially eligible cases on the waiting list. In the event of any drop out, the next eligible case will be selected to replace them.
5. The researcher will meet potential participants to complete the consent process and conduct initial screening. They will also meet them post intervention to undertake the semi structured interview. All other contact with the participant will be undertaken by the therapist.
6. The therapist will retain all measures until after completion of the intervention phase, when they will be passed to the researcher. The three month post intervention assessment will follow later.

7. The therapist will only discuss a participant with the researcher with regards to the following matters:
 - a. A client chooses to withdraw or is withdrawn by the therapist from the research project either by choice or by deviation from the intervention protocol.
 - b. At commencement and ending of the intervention and after collection of the three month post intervention data.
 - c. If a matter arises which may mean that it becomes appropriate to withdraw the participant from the project, but further information is needed from the researcher prior to making the decision. The decision will always be made by the therapist, possibly in conjunction with their clinical supervisor.
8. As much contact as possible will be by email to allow a record to be kept of therapist: researcher communication.
9. In the event of any issues arising which cannot be resolved between the researcher and therapist, Dr Penny Morgan, Consultant Clinical Psychologist will arbitrate.

UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Person Doing the Research



Mark Hardiman

Mark.hardiman@nchc.nhs.uk

01493 448400

Consent to Participate in a Research Study

This letter tells you about some research. We
would like you to help us with it. The research is



part of my training at the University of East London. It is being run by Norfolk Learning Disabilities Service.

Project Title

A mixed methods evaluation of the experiences of adults with learning disabilities and anxiety undertaking compassion focused therapy.

What is the Research?



The research is investigating Compassion Focused Therapy. This type of therapy helps you feel kinder towards yourself. You will talk to Corrina, practice things between meetings and do special exercises called meditations. This sort of therapy works with lots of people.



You will meet two people if you take part. Mark is the researcher. You will meet Mark at the start and end of the therapy. Corrina is the therapist. You will meet her every week during the therapy.

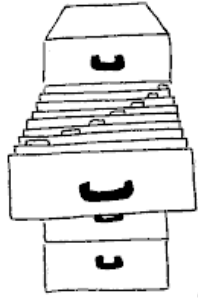


If you agree to take part, you will meet with Mark. Mark will fully explain the research. Then he will ask you to sign a form to say you understand what will happen. Finally he will complete three forms with you. Mark will read the forms to you and help you understand how to answer the questions. Corrina will then use Compassion Focused Therapy to help you instead of any other therapy. Like most types of therapy, this may take between twelve and fifteen meetings. After the therapy you will meet with Mark to talk about it. Mark will want to talk to you for about one to one and a half hours. This may be split over two meetings if you prefer. You will meet him after about a week, and briefly again after about three months. This is all you will need to do. Taking part might not give you any extra help, but it may help other people in your position in future.



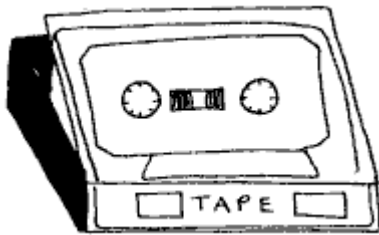
You can talk to Mark or Corrina about the research at any time. If you are ever unhappy about the research you can speak to Patient Advice and Liaison Services on 0800 088 4449. You can ask someone you trust to do this for you if you want.

Keeping Your Details Private



During the research, your details will be kept in a locked office where no one can see them by accident. Mark and Corrina's supervisors from the University of East London and Norfolk Community Health & Care NHS Trust may see your details so that they can check how the research and therapy is going.

When the research is finished, we will change your name on the notes so people don't know it's about you. Then we will write a report about the research and may publish this for other people to read. They will not know it's about you as your name will be changed. When we are finished anything with your name on it will be destroyed.



Your meeting with Mark after the therapy ends will be audio taped. The tape will be used to make a written copy of what you talk about.

After the research ends, the tape will be destroyed.

Location



You can decide where you would like to meet.

This might be at home, at your doctors or somewhere else like day services. Corrina and Mark will meet you at the same place.

Payment



You won't have to pay anything to take part in this research. You will not be paid for taking part in it.

Things you should know

You can say you don't want to take part. Corrina will still help you about feeling anxious. If you do not take part then you can still have the same



type of therapy. Corrina will talk to you about this and other options and agree with you what type of therapy you would like.p

If you or we decide this research is not the right thing for you to take part in, you will still be able to have other treatment from Corrina.

You can ask all the questions you want. If you want to take part you will sign a form to say you are happy. You should only sign this when we have answered all your questions and you are happy.

You can change your mind about taking part in the research after it has started. You or someone you trust can tell us and we won't mind. You don't have to tell us why. Corrina will still help you about feeling anxious.

We would like to tell your GP you are taking part in this study. We will only do this if you agree.

If you would like to learn more about how the therapy works, or you feel like you need any further support, then you or someone you trusts can contact:

Dr Anne-Marie Mensink, Norwich Community Learning Disability Team,
Room 026, County Hall, Martineau Lane, Norwich, NR1 2SG. Tel.: 01603
638520, anne-marie.mensink@nchc.nhs.uk

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor:

Dr James Walsh, School of Psychology, University of East London, Water Lane, London E15 4LZ. 020 8223 4471. j.j.walsh@uel.ac.uk

or the Chair of the School of Psychology Research Ethics Sub-committee:

Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: 020 8223 4493. m.finn@uel.ac.uk

Thank you.

Yours sincerely,

Mark Hardiman

Participant Information Sheet, Version 5.0. Dated 21st March 2013.

Appendix 5B.

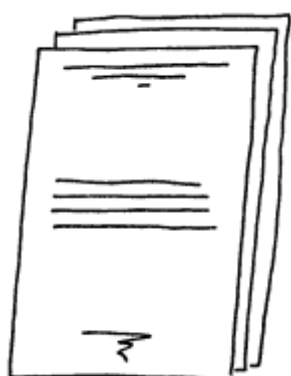
Consent Form

Participant Identification Number for this trial:

CONSENT FORM

A mixed methods evaluation of the experiences of adults with learning disabilities and anxiety undertaking compassion focused therapy

Name of Researcher: Mark Hardiman



I have the read the information sheet
dated 9th January 2013 (Version 4) and
have been given a copy to keep.

☐

The research has been explained to me.

☐

I have been asked if I have any questions.

I know what the research is about and
what I will need to do if I take part.



I know my details will be kept private. I
know that some of my medical notes may
be looked at by people from the
University of East London or from the
Learning Disabilities Service. I give
permission for these people to see my
records.

☐

I know that my meeting with Mark after
the therapy ends will be audio taped.

☐☐☐



I agree that Mark can write to my GP to
tell them I am taking part in the study.

☐☐

I know I can change my mind at any time
about taking part. I know Corrina will still
help me with my anxiety. I will not need
to say why I changed my mind.

☐

I agree to take part in the research.

Everything I want to know has been
explained to me.

Name of Participant

Date

Signature

Name of Person

Date

Signature

Appendix 5C

Letter to Participant's GP's

East Norfolk Community
Learning Disabilities Team
2nd Floor, Ferry House
South Denes Road
Great Yarmouth
Norfolk
NR30 3PR
Tel.No: 01493 841250
Fax.No: 01493 841281
Mark.hardiman@nchc.nhs.uk

27 September 2015

Name/ DOB/ Address

Your above patient has been referred to the South Norfolk Community Learning Disabilities Team for help with anxiety. They have agreed to take part in a research project entitled: A Mixed Methods Evaluation of the Experiences of Adults with Learning Disabilities Undertaking Compassion Focussed Therapy. I have enclosed a copy of the participant information sheet for you.

This project is exploring the experience of adults with learning disabilities when they undergo Compassion Focussed Therapy (CFT). CFT is a 'third wave' cognitive behavioural therapy intervention with a prime focus on helping people to improve their levels of self-compassion. Improved self-compassion may then help people regulate their levels of anxiety.

This project is being run within Norfolk Learning Disabilities Service by myself as part of my Professional Doctorate in Counselling Psychology at the University of East London. My contact details are shown above. The therapy will be delivered by my colleague Dr

Corrina Willmoth, who can be reached at the South Norfolk Learning Disabilities Team on 01953 450800.

If you would like to find out more about this project, or talk about your patient's participation in it then in the first instance please contact me at the above office.

Yours sincerely

Mark Hardiman

Trainee Counselling Psychologist

Gp letter version 1 dated 14th December 2011

Appendix 6. Interview Schedule

Theme 1. Overview

Can you tell me what your therapy was like? How did you get on? What was good about it? What was not so good about it? What did you find hard about it? What did you find easy about it?

Do you think your therapy has helped you? How has it helped you? How have you changed as a result of your therapy?

How would you describe your therapy to a friend? If a friend was feeling anxious, what would you suggest they do?

What do you think were the most important points about your therapy? What really helped you? What do you think was most important about your therapy?

Theme 2. Anxiety

How has your anxiety changed since you met Corrina? Do you feel more or less anxious? How does it feel different?

What was it about the therapy that helped your anxiety change? Can you tell me what it was about your therapy that helped you feel less (more) anxious?

Do you still feel anxious sometimes? What do you think about if you are feeling anxious? How do you react when you are anxious? What things from your therapy do you think about when you are feeling anxious?

Theme 3. Self-Compassion

What does self-compassion mean to you now? What did self-compassion mean to you before you started your therapy? How did the therapy change how you understood self-compassion? How would you describe self-compassion to a friend?

How has your self-compassion changed since you started therapy? What was it about therapy that has helped you to feel more (less) self-compassionate?

How do you think learning about self-compassion has affected your anxiety? Can you tell me how our anxiety changed as you became more self-compassionate?

Theme 4. The Therapeutic Relationship

Can you tell me what it was like working with Corrina? What was good about working with her? What did you find hard about working with her?

What sort of person is Corrina? How would you describe her personality?

What was it like working with Corrina on your anxiety? Was it easy or difficult to talk to Corrina about anxiety and self-compassion? Why was it easy talking to Corrina about anxiety and self-compassion?

Appendix 7a.

Adapted Self-Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost

Almost

never

always

1

2

3

4

5

- _____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
- _____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- _____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
- _____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
- _____ 5. I try to be loving towards myself when I'm feeling emotional pain.
- _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- _____ 8. When times are really difficult, I tend to be tough on myself.

- _____ 9. When something upsets me I try to keep my emotions in balance.
- _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- _____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
- _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- _____ 14. When something painful happens I try to take a balanced view of the situation.
- _____ 15. I try to see my failings as part of the human condition.
- _____ 16. When I see aspects of myself that I don't like, I get down on myself.
- _____ 17. When I fail at something important to me I try to keep things in perspective.
- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Glasgow Depression Scale

(score of 13 or over indicates depression).



| In the last week... | | Prompts | no | some times | a lot |
|---------------------|---|--|----|------------|-------|
| 1. |  | Have you felt sad? Have you felt upset, depressed, miserable, fed up, low? | 0 | 1 | 2 |
| 2. |  | Have you been in a bad mood? Have you felt bad tempered, wanted to shout at people? | 0 | 1 | 2 |
| 3. |  | Have you enjoyed doing things? Have you had fun? | 2 | 1 | 0 |
| 4. |  | Have you enjoyed talking and being with people? Have you liked having people around? | 2 | 1 | 0 |
| 5. |  | Have you had a bath/shower and changed your clothes? Have you taken care of the way you look / appearance? | 2 | 1 | 0 |
| 6. |   | Have you felt tired during the day? Have you gone to sleep during the day, found it hard to stay awake? | 0 | 1 | 2 |
| 7. |  | Have you cried? What made you cry? | 0 | 1 | 2 |
| 8. |  | Have you felt people don't like you? Have you felt you are a horrible person? | 0 | 1 | 2 |
| 9. |  | Have you been able to concentrate, such as watch TV? What is your favourite TV programme? Are you able to watch it all? | 2 | 1 | 0 |
| 10. |  | Have you found it hard to choose things? Have you found it hard to decide what to wear, eat or do? | 0 | 1 | 2 |

| In the last week... | | | Prompts. | no | some times | a lot |
|---------------------|---|--|---|----|------------|-------|
| 11. |  | Have you found it hard to sit still? | Have you fidgeted, moved around a lot more? | 0 | 1 | 2 |
| 12. |  | Have you eaten less? Have you eaten more? | Have people said you should eat more or less? | 0 | 1 | 2 |
| 13. |  | Have you found it hard to get a good night's sleep? | Have you found it hard to fall asleep, woken up a lot or too early? | 0 | 1 | 2 |
| 14. |  | Have you wished you were dead? | Have you wanted to stop living? | 0 | 1 | 2 |
| 15. |  | Have you felt everything is your fault? | Have you felt people blame you for things? | 0 | 1 | 2 |
| 16. |  | Have you felt people are looking at you, talking about you? | Have you worried about what other people think of you? | 0 | 1 | 2 |
| 17. |  | Have you been upset if people say you have done something wrong? | Do you feel sad, or feel like crying if someone tells you off? | 0 | 1 | 2 |
| 18. |  | Have you felt worried? | Have you felt nervous, tense, wound up or on edge? | 0 | 1 | 2 |
| 19. |  | Have you thought that bad things will happen to you? | Have you felt nothing nice happens to you? | 0 | 1 | 2 |
| 20. |  | Have you felt happy when something good happens? | What makes you feel happy? | 2 | 1 | 0 |

Cuthill, F. M., Esple, C. A., Cooper, S (2003) Development and psychometric properties of the Glasgow Depression Scale for people with a learning disability: Individual and carer supplement versions. *The British Journal of Psychiatry* 182:347-353. Adopted by MK, GU, GW, DHCI 1 2008.

Glasgow Anxiety Scale.

(score of 15 or above indicates anxiety).

| | | Prompts | no | some times | a lot |
|-----|---|--|----|---------------|-------|
| 1. |  | Do you worry a lot? Feel wound up, get worked up | 0 | 1 | 2 |
| 2. |  | Do you have lots of thoughts in your head? Can't stop thinking, can't keep thoughts away. | 0 | 1 | 2 |
| 3. |  | Do you worry about your family or friends? Think something bad will happen. | 0 | 1 | 2 |
| 4. |  2015 | Do you worry about the future? Link prompt to individual. | 0 | 1 | 2 |
| 5. |  | Do you worry that something bad will happen? | 0 | 1 | 2 |
| 6. |  | Do you worry about being ill? If you feel poorly. | 0 | 1 | 2 |
| 7. | | Do you worry about doing something new? Afraid to try new things. | 0 | 1 | 2 |
| 8. |  | Do you worry about what you are doing tomorrow? | 0 | 1 | 2 |
| 9. |  | Can you stop yourself worrying? Make yourself think about something else. | 2 | 1 | 0 |
| 10. |  | Do you worry about dying? | 0 | 1 | 2 |

| | | | Prompts. | no | some times | a lot |
|-----|---|---|--------------------------------------|----|---------------|-------|
| 11. |  | Are you scared of the dark? | Do you turn the lights off at night. | 0 | 1 | 2 |
| 12. |  | Do you feel scared when you are high up? | Do you like multi storey car parks. | 0 | 1 | 2 |
| 13. |  | Do you feel scared in lifts? | Would you get in one. | 0 | 1 | 2 |
| 14. |  | Are you scared of dogs? | Would you stroke one. | 0 | 1 | 2 |
| 15. |  | Are you scared of spiders? | Would you touch one. | 0 | 1 | 2 |
| 16. |  | Are you scared of going to the Doctor or Dentist? | Would you go if you needed to. | 0 | 1 | 2 |
| 17. |  | Are you scared of meeting new people? | Are you shy. | 0 | 1 | 2 |
| 18. |  | Are you scared in busy places or crowds? | Such as Westfield or Supermarkets. | 0 | 1 | 2 |
| 19. |  | Are you scared of open spaces? | Where there is nothing around you. | 0 | 1 | 2 |

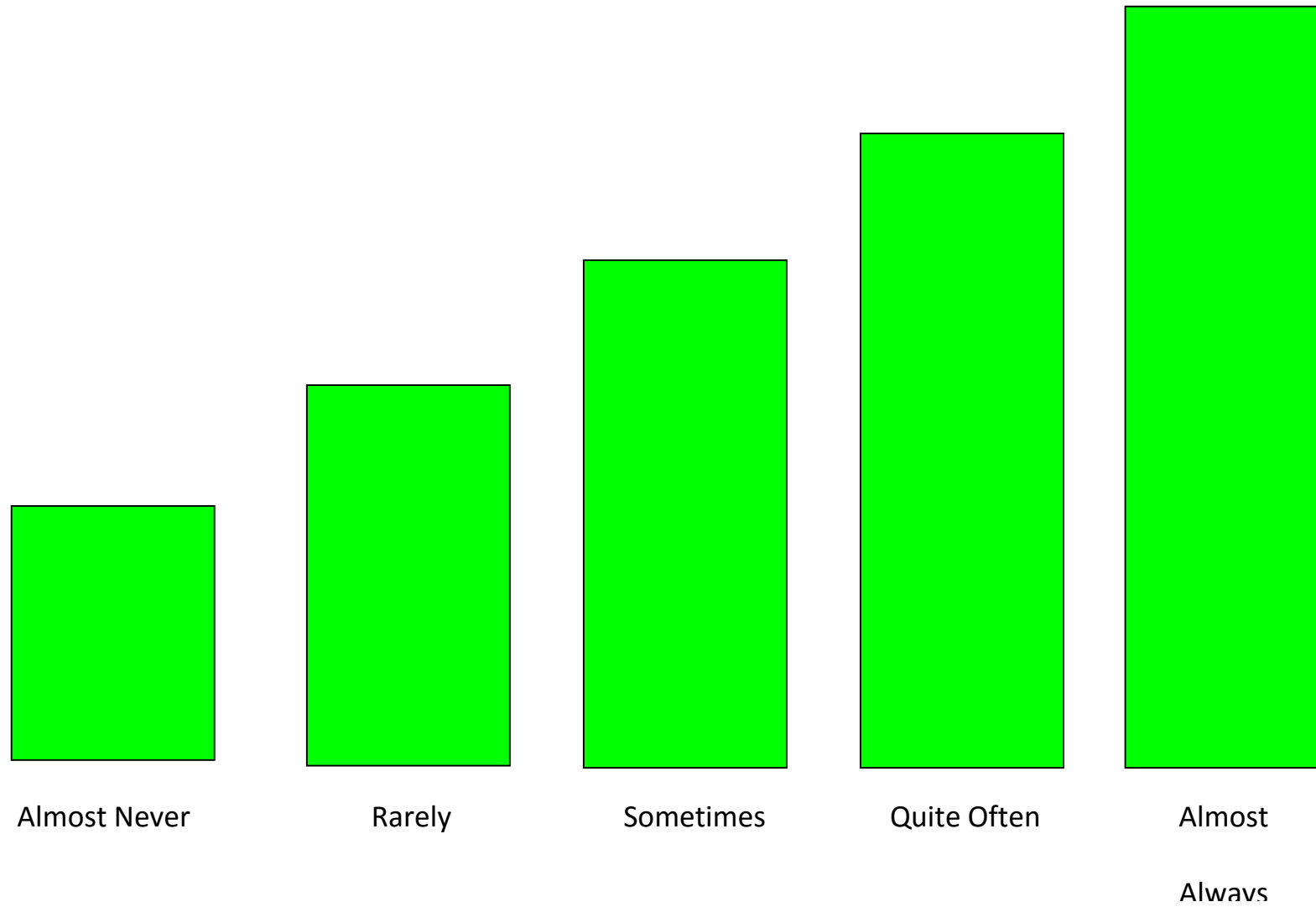
| | | | Prompts. | no | some times | a lot |
|----|---|---|---------------------------------------|----|---------------|-------|
| 20 |  | Do you get hot and sweaty? | All hot and bothered. | 0 | 1 | 2 |
| 21 |  | Does your heart beat fast? | Feel your heart is thumping. | 0 | 1 | 2 |
| 22 |  | Do your hands and legs shake? | | 0 | 1 | 2 |
| 23 | | Do you get butterflies in your stomach? | Knots in your stomach, fluttering. | 0 | 1 | 2 |
| 24 |  | Do you find it hard to breathe? | Are you out of breath a lot. | 0 | 1 | 2 |
| 25 |  | Do you have to wee more often? | | 0 | 1 | 2 |
| 26 |  | Is it difficult to sit still? | Feel you can't relax. | 0 | 1 | 2 |
| 27 | | Do you panic? | Get in a panic or a state. | 0 | 1 | 2 |

Mindham, J., Esple, C.A. (2003) Glasgow Scale for people with an Intellectual Disability (GAS-ID): development and psychometric properties of a new measure for use with people with mild intellectual disabilities. *Journal of Intellectual Disabilities* 47 (Pt 1):22-30. Adapted by Marsha Kerrigan and Gill Baker DHCFT 2013.

Appendix 7c.

Self-Compassion Scale Visual Analogue Chart

Self Compassion Scale Response Chart

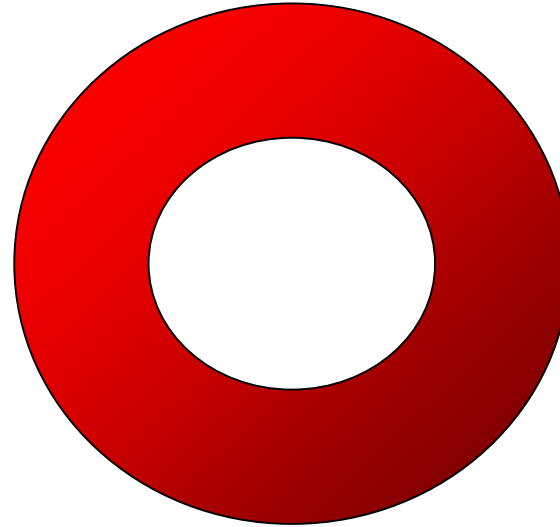


Appendix 7d.

Glasgow Scales Visual Analogue Chart



Always



Sometimes



Never

Appendix 8. Therapy Assessment Scale 2013

Therapy Assessment Guides

| <u>Microskills</u> | Absent or Inappropriate | | | | | Skilful Enactment | | | | | |
|---|-------------------------|---|---|---|---|-------------------|--|--|--|--|--|
| 1. Non-verbal communication 1: the therapist's attentiveness <i>appearance</i> of openness, friendliness of posture, facial expressions in contrast to defensive postures expressions | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 2. Non-verbal communication 2: the therapist's <i>voice tone</i> . | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 3. Pacing : the therapist's ability to provide space for the client to reflect and process information and emotion Focus 1: Facilitation of the client to stay focused rather than topic hop and wander away from central issues. Focus 2: Therapist is responsive to the client and is not inflexibly bound to their own agenda | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| Comments (including what went well and what could be improved) | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| 4. Open and Socratic dialogues: Use of open questions that invite exploration. For example utilisation of guide conversations and discovery for both therapist and client ; | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 5. Evidence, where appropriate of therapist tracking and reflecting on the three affect regulation systems: | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 6. Empathy 1: Therapist is sensitive and empathic to the client e.g., use of paraphrasing, summarising, validation, normalisation, mentalisation, empathic reflection. | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 7. Empathy 2: Therapist monitors client's ability to 'be understood' and receptive – can reflect on the process. "I notice that when I do say/do..... you seem to" | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| 8. Conceptualising: Therapist uses summaries, paraphrasing, and empathic reflection, with the ability to identify key themes in the client's narrative. Is able to locate content in the CFT model | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |
| Comments (including what went well and what could be improved) | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| <hr/> | | | | | | | | | | | |
| Formulation | | | | | | | | | | | |
| 9. 10. Background elicitation: Collaboratively developing a good understanding of the client's key early emotional experiences giving rise to an exploration of Self-to other(s); other-to-self(s); self-to-self; selves-to-selves relationships. Links to core motives and self-identities and goals – | 0 | 1 | 2 | 3 | 4 | 5 | | | | | |

| | Absent or Inappropriate | | | | Skilful Enactment | |
|--|----------------------------|---|---|---|----------------------|---|
| 10. Exploration of threat system activation: Elicit an individuals internal and external threats and concerns and linking them to background and present day experiences. | 0 | 1 | 2 | 3 | 4 | 5 |
| 11. Safety / protective strategies: Ability to help the client consider the development and function or <i>'intended consequence of safety / protective strategies'</i> and their links to the individuals experience of internal and external threats. | 0 | 1 | 2 | 3 | 4 | 5 |
| 12. Unintended consequences: Ability to help client become aware of, and think through, the unintended internal and external consequences of their safety and protective strategies in a non-judgemental, reflective way. | 0 | 1 | 2 | 3 | 4 | 5 |
| 13. Reflection: Ability to enable the client to reflect on their formulation, and understand the appropriate and inappropriate concept of "not your fault". | 0 | 1 | 2 | 3 | 4 | 5 |

Comments (including what went well and what could be improved)

Explaining the model

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. Understanding: Shows good understanding of the basic evolutionary model and the three affect regulation systems | 0 | 1 | 2 | 3 | 4 | 5 |
| 15. Psycho-education 1: Provision of appropriate information for the individual to appreciate the way our minds are 'set up'. Psychoeducation 2: Reflection that we can very easily become self-critical around very normal human characteristics, experiences etc | 0 | 1 | 2 | 3 | 4 | 5 |
| 16. Psycho-education 3: Discussion around, and reflection on, the three circle model that matches the individuals learning style and their current level of understanding. | 0 | 1 | 2 | 3 | 4 | 5 |
| 17. Psycho-education 4: Exploration into the value of developing mindful compassion (even if client thinks they would not be able to do it). Psychoeducation 5: Clarification of what compassion is and is not And exploration of common and individual 's blocks to it's development | 0 | 1 | 2 | 3 | 4 | 5 |

Comments (including what went well and what could be improved)

| <u>Contracting</u> | Absent or Inappropriate | | | | | Skilful Enactment |
|--|-------------------------|---|---|---|---|-------------------|
| 18. Task and goals: Articulation of the tasks and goals of therapy. | 0 | 1 | 2 | 3 | 4 | 5 |
| 19. Hopes and fears: Exploration of the client's hopes and fears around engagement with therapy. | 0 | 1 | 2 | 3 | 4 | 5 |
| Roles: Enabling the client to think about the roles of the therapist in facilitating guided discovery and practice and their (the clients) own input into the preparation and development of compassion | 0 | 1 | 2 | 3 | 4 | 5 |
| 20. Therapy plan: Collaboratively Develop an appropriate step-by-step therapy plan that is realistic whilst recognising that plans can change and develop over the course of therapy. | 0 | 1 | 2 | 3 | 4 | 5 |
| 21. Contracting: Able to contract for the number of sessions with a focus on likely content of sessions. | 0 | 1 | 2 | 3 | 4 | 5 |
| Comments (including what went well and what could be improved) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

CFT Interventions 1

| | | | | | | |
|--|---|---|---|---|---|---|
| 22. Attention training: Guides the client to understand the power of attention (a zoom lens, a focus and amplifier of emotion) | 0 | 1 | 2 | 3 | 4 | 5 |
| 23. Mindfulness: Guides the client to understand mindfulness and to begin some simple mindfulness exercises. | 0 | 1 | 2 | 3 | 4 | 5 |
| 24. Soothing breathing rhythm: Guides the client in this | 0 | 1 | 2 | 3 | 4 | 5 |
| 25. Imagery: appropriately discusses and explores imagery (what it is and what it is not), why it is important (how it affects our brains and bodies) | 0 | 1 | 2 | 3 | 4 | 5 |
| 26. Compassionate safe place / place of contentment: Enables the client to think about the concept , the qualities that would be important and experience this practice. | 0 | 1 | 2 | 3 | 4 | 5 |
| 27. Compassionate self: Enables the client to think about the concept of a compassionate self , the qualities that it would have and begin to practice those qualities. | 0 | 1 | 2 | 3 | 4 | 5 |
| 28. Compassionate image: Enables the client to think that the concept of a compassionate image and the qualities they would like it to have (and why). Reflection on and successful negotiation of issues and difficulties that may arise as a consequence of any such exercises. | 0 | 1 | 2 | 3 | 4 | 5 |

Comments (including what went well and what could be improved)

CFT Interventions 2

| | Absent or Inappropriate | | | | Skilful Enactment | |
|---|-------------------------|---|---|---|-------------------|---|
| 29. Explore emotion: Guides the client to understand cognitions, bodily experiences, behaviours and memories linked to different emotions. | 0 | 1 | 2 | 3 | 4 | 5 |
| 30. Explore Cognition: guides the client to elicit cognitive processes inference chains and how these are linked to emotional memory key fears: practice ways of the noticing and thought catching, de-centring, and re-evaluating and anti-rumination | 0 | 1 | 2 | 3 | 4 | 5 |
| 31. Compassionate engagement: Guides the client to understand and use compassionate focusing to re-evaluate or re-experience with guided discovery and gentle exposure. | 0 | 1 | 2 | 3 | 4 | 5 |
| 32. Compassionate chair work: Guides the client in the use of different chairs to identify, explore and communicate with different parts of the self. | 0 | 1 | 2 | 3 | 4 | 5 |
| 33. Compassionate letter writing: Guides the client in the use of writing about themselves and difficulties from a compassionate point of view. | 0 | 1 | 2 | 3 | 4 | 5 |
| 34. Compassionate behaviour: Guides the client in identifying compassionate behaviour in particular contexts that are important for them. | 0 | 1 | 2 | 3 | 4 | 5 |
| 35. Compassionate practice: Guides the client in appropriate practice and monitors practice. | 0 | 1 | 2 | 3 | 4 | 5 |

Comments (including what went well and what could be improved)

CFT Interventions 3

| | | | | | | |
|---|---|---|---|---|---|---|
| 36. Working with safety beliefs: Guides the client to explore their use of safety beliefs and how to change; behavioural experiments use of flash cards etc | 0 | 1 | 2 | 3 | 4 | 5 |
| 37. Working with safety behaviours: Guides the client to explore their use of safety behaviours and how to engage with behaviour experiments and regular practice in order to address these. | 0 | 1 | 2 | 3 | 4 | 5 |

| | Absent or Inappropriate | | | | Skilful Enactment | |
|--|----------------------------|---|---|---|----------------------|---|
| 38. Working with safety emotions. Guides the client to explore the use of safety emotions (one emotion covers another; issue of emotional avoidance) use of behavioural experiments and multiple self and chair work to address these | 0 | 1 | 2 | 3 | 4 | 5 |
| 39. Assertiveness and courage: Guides the client to differentiate between aggression and assertion and develop strategies and practices that may be of benefit | 0 | 1 | 2 | 3 | 4 | 5 |
| 40. Reliability of critic's view: Guides the client to look at the reliability of their critic. Differentiate between shame-based self attacking and compassionate self correction | 0 | 1 | 2 | 3 | 4 | 5 |
| 41. Fear of compassion: Guides the client to understand their fear of compassion and its consequences. | 0 | 1 | 2 | 3 | 4 | 5 |
| 42. Distinction between shame and guilt: Guides the client in their understanding of the distinction between shame and guilt and the importance of our ability to tolerate guilt. | 0 | 1 | 2 | 3 | 4 | 5 |
| 43. Grieving: Supports the client through the process of grieving for historical traumas. | 0 | 1 | 2 | 3 | 4 | 5 |
| 44. Conditioning: Guides the client in their understanding of the potential for fear and unpleasantness in relation to warm feelings. | 0 | 1 | 2 | 3 | 4 | 5 |
| 45. Rescripting: Guides the client to enlist the help of their compassionate self/image (if required) to discover and experience more realistic and helpful alternatives. | 0 | 1 | 2 | 3 | 4 | 5 |
| Comments (including what went well and what could be improved) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Appendix 9. Transcript One - MA

Mark 1 ... So, plan f yeah, what I'm here to do today then is to um talk with you about the time that you spent with Corrina

MA 1 Corrina

Mark 2 Perhaps to start with you could tell me about, the work that you did. What did you do with Corrina?

MA 2 Uh we done talking talking about cheerleaders. Which persons I like. Er, go have a walk around around the block

Mark 3 Mm

MA 3 She helped me go round round the block

Mark 4 Mm

MA 4 And I were she done she done a pictures for me

Mark 5 Mm?

MA 5 You know uh done a done like gaps you know

Mark 6 Mm

MA 6 I can't do the gaps properly and she h she helped me little bit

Mark 7 Mm

MA 7 That's bit hard to g go in the gaps

Mark 8 What gaps are you ref talking about

MA 8 Um er big gaps little gaps I don't like

Mark 9 What what when you're out and about?

MA 9 And about

Mark 10 Right

MA 10 I get fright I get little bit frightened

Mark 11 You get a little bit frightened

MA 11 yeah

Mark 12 when you're going through little gaps. mm

MA 12 Yeah

Mark 13 Okay

MA 13 As I like walking, I get a little bit panic you know

Mark 14 Mmm

MA 14 You know I get a little bit panic you know

Mark 15 And what's it like when you get a little bit panicked?

MA 15 Well er not not froze er I get panic you know I get tense up quick

Mark 16 Okay. Can you describe what it's like when you get tensed up

MA 16 I get I get erm you know a sh a little bit shaky bit shaken

Mark 17 Mm

MA 17 I get little tense up a little bit

Mark 18 Okay. And what else happens when you start to tense up and get shaky?

MA 18 I shake um like, my heart beat be beat little bit hard

Mark 19 Mm?

MA 19 Pumping up

Mark 20 Mm

MA 20 You know

Mark 21 And how does it make you feel when all that's going on?

MA 21 That's alright I can keep it down little bit. If someone help me you know I can do it

Mark 22 Mm

MA 22 You know if someone help me that that's a little bit cooled down

Mark 23 She's helped you to keep it a bit calmed down

MA 23 Calmed down and uh she do a she helped me uh breathing

Mark 24 Mm

MA 24 Breathing go (*demonstrates breathing in and out*) like that

Mark 25 Mm

MA 25 And she helped me do that exercise

Mark 26 Mm hm

MA 26 And other you know like that

Mark 27 Right

MA 27 You know done all sorts of other

Mark 28 Mm

MA 28 You know you know she she done wonderful

Mark 29 Mm

MA 29 And it

Mark 30 Okay. What would. So what was it like doing that work with Corrina

MA 30 I got I got on alright with her you know

Mark 31 Mm. Yeah

MA 31 And er she didn't moan or nothing

Mark 32 Okay

MA 32 She she know what got got you know she know got a little bit panic she know straight away

Mark 33 Mm?

MA 33 She she know straight away. Like crossing over the roads she help me

Mark 34 Mm

MA 34 Cross ov. A bit nervous. Nervous um. Um a bit nervous crossing over the road I hold her hand. Not her hand. Hold by b..

Mark 35 Right

MA 35 Tell tell me how how to cope me

Mark 36 mm. So you went out together and you did some walking together did you?

MA 36 Get me out

Mark 37 Yeah. What was that like to do?

MA 37 That was alright little bit I was little bit panic

Mark 38 Mm

MA 38 Y' know I get tense up little bit

Mark 39 Mm okay but Corrina was there with you

MA 39 Yeah

Mark 40 mm. How do you think it. What was it like having Corrina there when you were doing that?

MA 40 She she um she understand me

Mark 41 What do you mean by that when you say she understands you

MA 41 She know er you know I fee I feel you know like like she know I tell her every everything wrong with me

Mark 42 Mm. okay

MA 42 Next one (laughs)

Mark 43 Next question. Okay. So what would you say where the, good things about the work that you did together? What was good about it?

MA 43 Er she helped me to um help me go on erm tablet tablet on it she go um you know there

Mark 44 mm

MA 44 she get my cheerleaders up little bit you know little pictures little pictures. She done that

Mark 45 mm

MA 45 She bin train doing like that. Exercise.

Mark 46 Right okay. So she got you doing what putting your arms out?

MA 46 Arms up yeah

Mark 47 Yeah okay and how did that help things what was that about

MA 47 That was alright you know I been dancing a cheat er not cheating do exercise for her

Mark 48 Right. So she got you doing some exercise

MA 48 I dun I done it.

Mark 49 You done it

MA 49 Yeah

Mark 50 Okay what was that like to do

MA 50 At's alright. I keep doing it

Mark 51 You do. Okay. How often do you do it

MA 51 I do it often upstairs

Mark 52 Mm

MA 52 You know by myself and downstairs

Mark 53 Right. What it is about down what is it about being upstairs

MA 53 Uh I don't I don't come downstairs often

Mark 54 No

MA 54 You know um I keep in my room often you know

Mark 55 mm. where do you prefer to be upstairs or downstairs

MA 55 Er b um downstairs I think you know

Mark 56 mm. what is it you prefer about being downstairs

MA 56 I got I got mum I got me you know I got the budgie

Mark 57 Mm

MA 57 Not mm the budgie you know um you know I got the whole room I can sit down properly

Mark 58 Okay. What ab did you before Corrina met with you did you like being down here then or would

MA 58 yeah

Mark 59 Yeah? Okay or would you say it's changed since Corrina

MA 59 It ain't changed at all

Mark 60 No? Same as it was before

MA 60 I didn't got nervous around or nothing

Mark 61 Okay okay

MA 61 The first met her I got a bit nervous a little bit

Mark 62 Yes a new person that's

MA 62 When I first met met her a bit a bit <unclear> her

Mark 63 Mm
 MA 63 You know
 Mark 64 What's it like when you feel nervous how did you know you were feeling nervous
 MA 64 Uh you sh you sh you shake
 Mark 65 Mm
 MA 65 You get I get tense up. It's like when they're people coming I shake
 Mark 66 Mm
 MA 66 You know
 Mark 67 Um obviously we've met before so what was it like when I came round today
 MA 67 Er that's alright today you know I haven't tensed up at all
 Mark 68 You haven't? oh okay
 MA 68 No
 Mark 69 Why do you think that is?
 MA 69 I don't know why you know I I um I'm normal look
 Mark 70 You're hands are very still aren't they
 MA 70 still
 Mark 71 Mm
 MA 71 Some people come round and I've I get tense up you know I shake like
 Mark 72 Mm
 MA 72 I got I got I take tablets too
 Mark 73 Mm? You were taking tablets when we met last time I think weren't you?
 MA 73 Yeah
 Mark 74 Yeah okay they haven't changed in the last
 MA 74 That haven't changed at all
 Mark 75 OK so what sort of people what happ. When some people come round you shake
 MA 75 I shake
 Mark 76 What people
 MA 76 Err MENCAP you know doing help me wa wa walking around you know
 Mark 77 Mm
 MA 77 I get tense up a little bit you know
 Mark 78 Right. So you get tensed up a bit when MENCAP
 MA 78 'CAP when they. Some people are like you know you know some people are like you know
 Mark 79 Mm
 MA 79 I getting used to them
 Mark 80 Mm
 MA 80 I get tense up sometimes
 Mark 81 Would you say, you get more tensed up now or less tensed up now
 MA 81 'at's cooled down now
 Mark 82 Right and why do you think that is
 MA 82 I don't know why
 Mark 83 Mm
 MA 83 You know I don't know why n that
 Mark 84 Do you think it's changed since you started seeing Corrina?

| | |
|----------|--|
| MA 84 | Um not really that's gone that's gone that's getting better |
| Mark 85 | Mm |
| MA 85 | Get better you know |
| Mark 86 | Mm Try and help me try and understand what's different then why |
| MA 86 | You know she you know she um can't remember now um I get I g I didn't get tense up at all |
| Mark 87 | You didn't |
| MA 87 | No |
| Mark 88 | Okay. So what things do you think she did that you found really good and you enjoyed |
| MA 88 | Um she's a she's a lack she relax you know um |
| Mark 89 | Mm |
| MA 89 | Relax err the |
| Mark 90 | Right the relax |
| MA 90 | right |
| Mark 91 | Can you describe for me what you did |
| MA 91 | Do um deep breathing |
| Mark 92 | Yeah |
| MA 92 | You know um on the CD I got um 'lets' CD you can make the words sometimes |
| Mark 93 | Right |
| MA 93 | And I got a CD in now |
| Mark 94 | OK |
| MA 94 | And I say relax and go make the stories out |
| Mark 95 | Mm. Tell me about those stories |
| MA 95 | That's um that's um relax um you go you have it like this |
| Mark 96 | Mm so you sit back |
| MA 96 | Sit get back relax |
| Mark 97 | Yeah |
| MA 97 | And I'll put the CD say where there's a song people talk about it |
| Mark 98 | Mm |
| MA 98 | And she could do it like this |
| Mark 99 | Tensing your shoulders yeah |
| MA 99 | Yeah and that |
| Mark 100 | Hands |
| MA 100 | And she'd do like that |
| Mark 101 | Oh right OK so you tense all your body up |
| MA 101 | Yeah I done it like that |
| Mark 102 | Right |
| MA 102 | Go like that |
| Mark 103 | So you tense up and relax |
| MA 103 | relax |
| Mark 104 | yeah |
| MA 104 | She done she er she do it like that |
| Mark 105 | Mm |
| MA 105 | Go tense so like like that |
| Mark 106 | Mm hm Okay so you tense all your body up and then you relax |

MA 106 Go relax yeah go go like this
 Mark 107 Yeah
 MA 107 Go like that she teach me that uh she did
 Mark 108 And was that something you enjoyed doing or didn't enjoy doing
 MA 108 Yeah I like it
 Mark 109 Mm is that something you still do
 MA 109 I still do
 Mark 110 Yeah okay what other things did you enjoy about it
 MA 110 I like her deep breath and I keep keep calm
 Mark 111 Mm
 MA 111 Go (*breathes in and out deeply*) like that
 Mark 112 Yeah
 MA 112 Ten times
 Mark 113 Yeah okay and the keep calm
 MA 113 Keep calm (*coughs*)
 Mark 114 Mm
 MA 114 Keep calm you know
 Mark 115 Do you still use those things Do you still do them?
 MA 115 I do it I do it often sometimes
 Mark 116 Mm
 MA 116 I feel like it
 Mark 117 Yeah. Have you done it today
 MA 117 Not today no don't need it
 Mark 118 You don't need it today so you just do it when you need it
 MA 118 Need it
 Mark 119 Mm how do you know when you need it
 MA 119 I get like a bit pani like a bit panic
 Mark 120 I see okay. So it's something you do when you start to feel a little bit panic
 MA 120 Panic yeah
 Mark 121 And how does it change things when you do that
 MA 121 It um I don't know 'at's um er bit shaken
 Mark 122 Mm
 MA 122 Bit shaken you know when I go out
 Mark 123 Yeah
 MA 123 Like that I'll go out I shake
 Mark 124 Mm
 MA 124 You know
 Mark 125 Yeah
 MA 125 'at's a thing call it call it now er can't remember 'at's say say it Mark
 Mark 126 I think I know what you mean
 MA 126 So so xiety can't say it you know a lot of people can't go out properly can't
 walk round
 Mark 127 yeah
 MA 127 You know
 Mark 128 Are you going out more now or less now
 MA 128 Er um er two times now
 Mark 129 Two times

MA 129 Two times now. I been I been twice today
 Mark 130 You've been twice today. Where did you go today
 MA 130 Yeah round the block
 Mark 131 Mm? and what was that like?
 MA 131 At was alright I keep m er 'at's alright sometimes ya know
 Mark 132 Mm
 MA 132 You know he got you know he's alright you know
 Mark 133 He's alright
 MA 133 Yeah
 Mark 134 What do you mean by that?
 MA 134 I te r he hear he suit me little bit you know he's he's cooled down now
 Mark 135 Mm
 MA 135 He got not got tol off you know he push me too much he did
 Mark 136 Mm
 MA 136 You know um you know he's cooled down he he he help me now
 Mark 137 This is your support worker
 MA 137 Yeah
 Mark 138 Yeah okay
 MA 138 He he cooled down now
 Mark 139 Mm
 MA 139 You know which he you know um I like him now
 Mark 140 You like him now
 MA 140 Ay
 Mark 141 Yeah okay
 MA 141 You you he make me cry he did
 Mark 142 Did he? That's not good what happened?
 MA 142 Uh I ha had too much walking
 Mark 143 Mm
 MA 143 Had um three um no four walks I didn't like it at all
 Mark 144 Mm
 MA 144 You know I cry you know
 Mark 145 Right. And what happened when you cried
 MA 145 Erm. Had a little cry I cried I did up the road
 Mark 146 Mm
 MA 146 You know
 Mark 147 Mm
 MA 147 Ye well what's her name I can't remember now C'ina
 Mark 148 Corrina
 MA 148 Corrina, she see'd her up the road I cried up the road so that's how what's
 hap what happened you know that I stopped (*clears throat*) sorry mark I
 say why what happened and I cried
 Mark 149 mm. And what was that like to do
 MA 149 Oh I get upset you know
 Mark 150 Mm when you got upset with Corrina how did it
 MA 150 No no not upset no um a different person
 Mark 151 Oh okay
 MA 151 Yeah you know

Mark 152 With your support worker
 MA 152 I told her I did
 Mark 153 Yeah I and what was it like to tell her
 MA 153 At was alright, get it out my system
 Mark 154 You got it out of your system
 MA 154 Yeah
 Mark 155 Mm was it a difficult thing to tell her or an easy thing to tell her
 MA 155 Ea bit easy
 Mark 156 Bit easy?
 MA 156 Bit easy
 Mark 157 Mm good
 MA 157 You know
 Mark 158 Okay. So what do you think were the difficult things to do in your therapy with Corrina. What was it what was it she tried to get you to do that was really hard
 MA 158 Erm get me walk walking
 Mark 159 Mm
 MA 159 Could see she could wa walking
 Mark 160 Mm
 MA 160 Um she's done a good job
 Mark 161 Mm?
 MA 161 Um you know she hel helped me a lot she did
 Mark 162 She helped you a lot
 MA 162 Yeah
 Mark 163 Okay. Remind me before you met Corrina did you go out walking?
 MA 163 Not not really I I choosed it
 Mark 164 Right
 MA 164 I ch chosed it you know um go out like that
 Mark 165 OK so you didn't really go out you on you didn't really choose to go out before
 MA 165 Before
 Mark 166 But you said today you went out twice
 MA 166 Twice yeah
 Mark 167 Wow. So what's that what's it like kinda that change. What's that all about do you think
 MA 167 Err I don't know I get I get tense up a little bit up up near the up the top there
 Mark 168 Mm
 MA 168 I get real tense up
 Mark 169 Do you still get tensed up or
 MA 169 Err yea
 Mark 170 And what happens when you get tensed up now
 MA 170 Er I get tense up like that
 Mark 171 Yeah. I guess what I'm thinking about is, um you used to go out and get tensed up
 MA 171 Yeah
 Mark 172 And it used to stop you going out is that right?

MA 172 Yeah
 Mark 173 Now you go out and you get tensed up but you still go out
 MA 173 Still go out
 Mark 174 So why has it changed what's different
 MA 174 I don't know um I don't know what happened you know um like that
 Mark 175 Mm? but something's changed
 MA 175 Bit changed a little bit
 Mark 176 Mm do you think you get as tense now as you used to or do you think you
 get more tense or less tense
 MA 176 A little bit tense a little bit
 Mark 177 Cos you used to get a little bit tense
 MA 177 Tense up yeah
 Mark 178 OK. Do you think you used to get. Before you met Corrina
 MA 178 Yeah
 Mark 179 Do you think you were more tense than you are now or less tense than you
 are now
 MA 179 I think I was more tense up
 Mark 180 More tense up. So before you met Corrina you were more tense
 MA 180 More t yeah
 Mark 181 Now you're less tense
 MA 181 Yeah
 Mark 182 How would you describe the difference
 MA 182 A bit sh bit shaky
 Mark 183 Mm hm. Are you saying that you would be more shaky now or less shaky
 now
 MA 183 Now I'm alright now
 Mark 184 You're alright now
 MA 184 Yeah I go out a bit shaky
 Mark 185 You go out and you're a bit shaky
 MA 185 Yeah
 Mark 186 But, before that you were a lot shaky
 MA 186 Shaky yeah
 Mark 187 Is there anything else apart from shaky that's different
 MA 187 That's it that's it
 Mark 188 Right okay. Now you're going out, twice a day, how do you feel about going
 out, is it something
 MA 188 I like I like going out
 Mark 189 You like going out
 MA 189 Going out
 Mark 190 Mm
 MA 190 It's a main road it's a main road and like
 Mark 191 Mm
 MA 191 I might seize up and get little bit panic
 Mark 192 Right
 MA 192 I get a little bit panic n I get near the main road I get panic
 Mark 193 Mm
 MA 193 And I get tense up quick

| | |
|----------|---|
| Mark 194 | Mm |
| MA 194 | And that you know |
| Mark 195 | Mm. okay so you still ge if you go near main roads |
| MA 195 | Yeah |
| Mark 196 | You tensed up |
| MA 196 | I tense up yeah |
| Mark 197 | Yeah But you can go round here |
| MA 197 | Go round here |
| Mark 198 | Which you couldn't do before |
| MA 198 | No |
| Mark 199 | Is that a so what's it like now when you go round here now when you couldn't do that before |
| MA 199 | 'at's alright you know |
| Mark 200 | Mm |
| MA 200 | And I I like it you know |
| Mark 201 | You like it |
| MA 201 | I like it now |
| Mark 202 | What do you think it says um no I don't mean that what was I trying to say what I'm trying to say is um, do you think it's a good thing that you can go out and do that now |
| MA 202 | Yeah I do now |
| Mark 203 | Yeah okay |
| MA 203 | 'at is like at is like I can't cross over you know I get little bit panic |
| Mark 204 | Mm |
| MA 204 | You know |
| Mark 205 | So you still can't cross over |
| MA 205 | Can't go over no |
| Mark 206 | Okay |
| MA 206 | Still can't ride my bike still |
| Mark 207 | Okay. So you've got better |
| MA 207 | Yeah |
| Mark 208 | Doing things you didn't used to do, but there's other things you've still not doing |
| MA 208 | Doing yeah |
| Mark 209 | So does that mean it was all really good or does that mean |
| MA 209 | Er uh now I don't go near the bush now |
| Mark 210 | Right |
| MA 210 | I used to get near the bush |
| Mark 211 | Mm |
| MA 211 | Now um little bit out |
| Mark 212 | Okay so you ride a little bit further out |
| MA 212 | Further out now |
| Mark 213 | What's that like to do |
| MA 213 | 'at's alright. Little bit little bit panic |
| Mark 214 | Right |
| MA 214 | Little bit |

Mark 215 Why does what's the difference then why do you ride further out from the bush
 MA 215 Now now um Im getting used to it
 Mark 216 Mm
 MA 216 I don't get panic now
 Mark 217 Mm
 MA 217 Now that's alright you know
 Mark 218 Mm
 MA 218 I don't get ne near wall now
 Mark 219 Right
 MA 219 I'm I I'm in the middle
 Mark 220 Okay
 MA 220 I still can't walk you now uh the pathways not yet
 Mark 221 mm. still can't walk on the pathways
 MA 221 The pathways no
 Mark 222 No? what's difficult about that?
 MA 222 That's uh that's bit hard that might get um I might fall over
 Mark 223 mm. You might fall over
 MA 223 I might fall over
 Mark 224 OK. Have you ever fallen over?
 MA 224 Once that's all
 Mark 225 Once. How long ago was that
 MA 225 'at's done a long time
 Mark 226 Just a long time ago. OK so you fell over a long time ago but you're worried it might happen again
 MA 226 Yeah
 Mark 227 mm. okay. What what would what would happen if you fell over
 MA 227 I get panic
 Mark 228 You get panicked. Mm
 MA 228 I get panic you know
 Mark 229 Mm
 MA 229 Yeah I get panic you know
 Mark 230 mm. so if you fell over you'd get panic
 MA 230 Yeah panic
 Mark 231 And what would you do if you got panicked?
 MA 231 I might fall over
 Mark 232 Right okay
 MA 232 You know
 Mark 233 But if you did fall over
 MA 233 Get up
 Mark 234 You'd get up
 MA 234 I might fro might froze
 Mark 235 You might froze. Okay have you frozen recently
 MA 235 Uh er well las last year
 Mark 236 Last year
 MA 236 I went up the Norman Centre
 Mark 237 Mm

MA 237 Up the up the Norman Centre I got at work you know at work you know
I've froze load of times

Mark 238 Mm

MA 238 You know crossing over roads you know I got no help no help at all

Mark 239 Mm

MA 239 And when I ask people, strange people when I ask people cross me over the
road

Mark 240 Mm

MA 240 You know a lot of people help me little bit

Mark 241 Mm

MA 241 I didn't need helpers at all

Mark 242 Mm

MA 242 And it a bit bit hard

Mark 243 Yeah is that any different now would that be any different now do you
think

MA 243 That's still the same

Mark 244 Still the same?

MA 244 Keep practicing keep practicing

Mark 245 Mm

MA 245 Int gone not yet

Mark 246 OK tell me about tell me more about the way that you're practising

MA 246 Uh me um when the people do it MENCAP uh crossing over the roads

Mark 247 Mm

MA 247 They hold that hold me properly

Mark 248 Holding your arm yeah

MA 248 No uh hold this

Mark 249 Oh okay yeah

MA 249 They don't hold me properly

Mark 250 Right

MA 250 'ey hold me on this

Mark 251 Yeah

MA 251 And no I see how I fall over

Mark 252 Mm

MA 252 Like that

Mark 253 right okay. So this, sort of we've been talking lots about the panic and how
you feel panicky here

MA 253 Yeah

Mark 254 Um when you are feeling panicky, do you think Corrina's helped that get
better or do you think

MA 254 Yeah she helped me bit better

Mark 255 Right

MA 255 I can understand her I did

Mark 256 You understood her

MA 256 Yeah

Mark 257 So she was able to explain it all to you. Yep good okay. Do you think your
when you feel panicky do you think is that any different now what's
different about it

MA 257 I don't know I don't know
 Mark 258 Mm
 MA 258 You know sometimes I do it you know
 Mark 259 Mm. does it does it worry you as much as it used to
 MA 259 Mm I used to do load a break loads of times
 Mark 260 mm. What about now
 MA 260 I still do I do I worry
 Mark 261 Do you worry as much as you used to
 MA 261 Yeah
 Mark 262 Is it more or less
 MA 262 More
 Mark 263 More?
 MA 263 More
 Mark 264 More. Tell me about why how you worry more
 MA 264 I get little bit panic I get tense up quick
 Mark 265 Mm
 MA 265 Sometimes I cry sometimes
 Mark 266 Mm. Did you used to do those things before you met Corrina
 MA 266 No
 Mark 267 No. Okay. What do you think has what do you think has lead you to to cry
 now and get more tensed up and panicked
 MA 267 Um now Im getting a bit little bit bit better now
 Mark 268 Mm
 MA 268 With people it go down a little bit
 Mark 269 Mm
 MA 269 And they these keep understand me
 Mark 270 Mm
 MA 270 Gotta do you know now they'll go down little bit
 Mark 271 Mm
 MA 271 Do less a little bit going out now
 Mark 272 Mm
 MA 272 Do it twice now
 Mark 273 Mm
 MA 273 A thr do it four times that's too much
 Mark 274 Okay
 MA 274 I cut it down to two now
 Mark 275 Mm okay so you were going out too often
 MA 275 Too often
 Mark 276 And it was but now you've cut it back
 MA 276 Cut it back
 Mark 277 And you're only going out twice
 MA 277 Twice yeah
 Mark 278 But you're enjoying going out twice
 MA 278 Yeah I yeah
 Mark 279 Okay. So what do you think are the things that Corrina did with you that
 helped you to feel less panicky
 MA 279 Uh. You know she's do me good

Mark 280 Mm what did she do
 MA 280 She w
 Mark 281 That was what did she do that helped do you think
 MA 281 Help uh help me you know
 Mark 282 Mm
 MA 282 She helped me she she understand me
 Mark 283 Hm she understood you
 MA 283 Yeah
 Mark 284 How did she do that
 MA 284 She helped me little bit
 Mark 285 Mm
 MA 285 We went into Kerrisons last week
 Mark 286 Right okay
 MA 286 And I say let go let go
 Mark 287 Mm
 MA 287 You know and a bit hard for me she went in and said that's my last day I
 went up there Kerrisons
 Mark 288 Yeah that's quite. I mean that means going up on the main road doesn't it
 MA 288 Yeah
 Mark 289 Mm
 MA 289 She helped me get on the paths you know um
 Mark 290 Right
 MA 290 She helped me go in there I me in the shop I'm alright
 Mark 291 Mm you're alrigh you're alright in the shop
 MA 291 Shops yeah
 Mark 292 Okay. What's different about being in the shop?
 MA 292 Er that's a bit closed in
 Mark 293 Mm. It's a bit closed in
 MA 293 Closed in yeah
 Mark 294 Mm. What's different about being out of the shop
 MA 294 The shop. The paths bit bigger
 Mark 295 The paths a bit bigger
 MA 295 Yeah I can't do it
 Mark 296 You can't it
 MA 296 Can't do it
 Mark 297 Okay
 MA 297 I froze
 Mark 298 You froze mm. What is it about the paths being bigger that made you
 freeze
 MA 298 I don't know what um I don't know why
 Mark 299 Mm
 MA 299 I don't know why mark
 Mark 300 Mm okay. you said that, um Corrina understood you
 MA 300 Ah
 Mark 301 I'm interested in that tell me more about how she understood you
 MA 301 I told that I told her wa was wrong with me I told her everything 'bout it
 you know

Mark 302 Mm
 MA 302 And she un understand me
 Mark 303 Mm
 MA 303 And I've um she she know about it you know
 Mark 304 Mm
 MA 304 You know I told her everything I did
 Mark 305 Mm
 MA 305 You know er that was you know if it got too much I told her I do the people
 you know I told her I told her
 Mark 306 Mm
 MA 306 You know you know um she's done a good job
 Mark 307 Okay how tell me about her doing a good job what does that mean
 MA 307 She's a good helper
 Mark 308 Mm
 MA 308 She's a good helper she's good n listening
 Mark 309 Mm
 MA 309 She help me a lot
 Mark 310 Mm
 MA 310 I like her I like her paperwork
 Mark 311 Her drawings yeah
 MA 311 Her drawings
 Mark 312 Yeah
 MA 312 She understand her drawing
 Mark 313 Mm
 MA 313 Uh what is it we doing the uh that's the first one I'll show you this one
 Mark 314 Yeah
 MA 314 There's that's like
 Mark 315 yeah
 MA 315 I say to her that's her that's her friend see
 Mark 316 Mm hm
 MA 316 I can't do it
 Mark 317 Okay so she drew out the hedges and fences for you
 MA 317 Fences
 Mark 318 Okay cos you keep to the hedges and fences
 MA 318 'at's the as the main road
 Mark 319 Yeah
 MA 319 'at's m as me on the bike
 Mark 320 Right okay. So she drew that all out for you okay
 MA 320 Yeah
 Mark 321 Did she know that why did she draw them out for you
 MA 321 She remind me
 Mark 322 Right to remind you
 MA 322 Remind me yeah I told her what's going on and she
 Mark 323 Mm. I told her what was going on
 MA 323 Going on
 Mark 324 And she drew it all down to remind you
 MA 324 Yeah

Mark 325 Okay. And that felt like she was understanding you
 MA 325 Ay
 Mark 326 mm. Are there any other things she did that helped you feel like you were understood
 MA 326 You know I like I like her deep breaths
 Mark 327 Right
 MA 327 I like like like exercise
 Mark 328 You like the deep breaths and the exercises
 MA 328 exercises yeah
 Mark 329 Yeah okay
 MA 329 Tha that tha did work
 Mark 330 Mm
 MA 330 That did work a load of times
 Mark 331 That helped work a load of times
 MA 331 Load of times
 Mark 332 Mm okay did she, did she teach you to just do those when you were feeling panicky
 MA 332 Panic panic
 Mark 333 Or to do them all the time
 MA 333 All the time
 Mark 334 Right even if you're not feeling panicky
 MA 334 Panicky
 Mark 335 Mm okay but what Corrina did was she understood you and she
 MA 335 Yeah
 Mark 336 Yeah. What's that like have you ever had anything like happen before where someone's understood you like that
 MA 336 No not really
 Mark 337 No. can you think of anyone else whose ever understood you like that
 MA 337 No not really
 Mark 338 Okay
 MA 338 Not really
 Mark 339 Mm so someone understood you and it hasn't really happened before
 MA 339 No
 Mark 340 Mm what was that like
 MA 340 That was wonderful
 Mark 341 Wonderful
 MA 341 Uh
 Mark 342 Okay. I wonder if it was a strange thing unus you know you weren't used to it
 MA 342 Weren't used to it
 Mark 343 Mm
 MA 343 I me I me I meet new people
 Mark 344 Mm
 MA 344 You know I get I get tense up when get new people
 Mark 345 Mm
 MA 345 I get tense up
 Mark 346 Mm

MA 346 I first met her I got I got tense up
 Mark 347 Yeah? And how did she help you to get less tense
 MA 347 I calmed little bit down little bit
 Mark 348 Mm okay
 MA 348 You know
 Mark 349 Mm. Okay so what would you say um I'm interested now in how you got on
 with Corrina
 MA 349 'ight
 Mark 350 I what was good about working with Corrina what do you think wh
 MA 350 I don't know I don't know wh uh I don't know Mark
 Mark 351 Mm
 MA 351 You know she's, say something
 Mark 352 No you were going to say something go on
 MA 352 (Laughs) you know she did help me a lot
 Mark 353 Mm okay
 MA 353 you know
 Mark 354 what did you find hard about working with Corrina
 MA 354 No uh bit uh she's alr she's been alright so far
 Mark 355 Mm
 MA 355 You know er she understand when I cried she know wha what happened
 Mark 356 Mm
 MA 356 You know she n understand me
 Mark 357 Mm
 MA 357 You know
 Mark 358 Did you cry in front of Corrina
 MA 358 I did
 Mark 359 Yeah
 MA 359 I did you know
 Mark 360 And what was that like to do
 MA 360 That's a that's a that's in my report um she writing a le letter
 Mark 361 Mm
 MA 361 You know I been crying I been crying up the road
 Mark 362 Mm
 MA 362 You know I get she give me little bit cuddle
 Mark 363 Right
 MA 363 And I've erm bit up set upset me
 Mark 364 Mm
 MA 364 You know it's like on my piece of paper
 Mark 365 Mm
 MA 365 You know the she did help me
 Mark 366 Mm
 MA 366 You know I cried little bit you know
 Mark 367 Okay she helped you when you cried
 MA 367 Cried yeah
 Mark 368 What was that like when she helped you
 MA 368 It ca cooled me down little bit
 Mark 369 Calmed you down a little bit

MA 369 Yeah
 Mark 370 Mm what else was it like how else could you describe it
 MA 370 Little bit cooled down
 Mark 371 Mm
 MA 371 Erm don't get tense up
 Mark 372 Mm okay
 MA 372 You know sometimes I bet um not go up not go down
 Mark 373 Mm do other people help you if you cry
 MA 373 Sometime you do
 Mark 374 What's how do they
 MA 374 Bother it up I do if some go um you know if something bother me up I'll do it
 Mark 375 Mm
 MA 375 Make me cry
 Mark 376 Mm
 MA 376 You know
 Mark 377 Mm
 MA 377 Haven't done that lately, I've been good
 Mark 378 No? you've been good
 MA 378 I've been good
 Mark 379 OK when was the last time
 MA 379 I can't remember now
 Mark 380 Right
 MA 380 I've been good I haven't been crying, you know
 Mark 381 Mm okay how often would you normally cry do you think
 MA 381 Maybe if something set upset me
 Mark 382 Mm
 MA 382 You know if something 'set me. I'll cry I cry I do
 Mark 383 mm. Okay, there's nothing wrong with that
 MA 383 (laughs)
 Mark 384 Has anyone upset you recently
 MA 384 Uh I it did do me yeah
 Mark 385 Mm
 MA 385 It's it's been sorted
 Mark 386 It's been sorted did they make you cry
 MA 386 That make me cry yeah. Two people make me cry
 Mark 387 Mm who were those two people
 MA 387 Um can't remember um that's been sorted now
 Mark 388 How was it sorted out
 MA 388 That get I get tense up he come, you know um you know he didn't he didn't help me properly crossing over he he he let go
 Mark 389 Right
 MA 389 In the middle I get little bit panic
 Mark 390 Mm
 MA 390 he let go sometimes
 Mark 391 Okay what did what did Corri what did Corrina do that he didn't
 MA 391 He he she didn't let go

Mark 392 She didn't let go
 MA 392 No
 Mark 393 Okay so she held on as you crossed over
 MA 393 Crossed over yeah
 Mark 394 Mm and how was that diff how did that help you
 MA 394 That's alright
 Mark 395 Mm. how did it help you to know she didn't let go
 MA 395 I might get little bit relax
 Mark 396 Mm helped you get a bit more relaxed, okay... its half past four
 MA 396 Getting dark
 Mark 397 It is getting dark isn't it actually
 MA 397 I worry about you
 Mark 398 Oh I've got a car I'm alright
 MA 398 Oh you've got a car
 Mark 399 Yeah
 MA 399 Sorry
 Mark 400 That's alright it's not a problem. Um... yeah I'll be on the bike tomorrow
 when I come back tomorrow I'll be on the motorbike but that's fine still got
 lights not going to be a problem that its dark. Wha wh what's do you ever
 go out in the dark
 MA 400 No
 Mark 401 No
 MA 401 I never go in the dark at all
 Mark 402 No
 MA 402 Bit scary
 Mark 403 Bit scary. What is it about the dark that scares you
 MA 403 Too much people around
 Mark 404 Too much people around
 MA 404 A bit a bit nervous of people still
 Mark 405 mm okay mm. did Corrina try to help you with that
 MA 405 Yeah we int tried that one at all
 Mark 406 No
 MA 406 We int done that one at all
 Mark 407 Okay. Well you can't do everything
 MA 407 (laughs)
 Mark 408 That's okay. So how much do you think. How much do you think things
 have changed for you since you started meeting Corrina
 MA 408 I um that's alright
 Mark 409 Mm
 MA 409 I er I er I'm used to it
 Mark 410 Mm
 MA 410 You know um I'm used to her you know
 Mark 411 mm. You're used to her
 MA 411 Yeah
 Mark 412 Mm
 MA 412 She uh bit uh she make me she left I think last week
 Mark 413 Mm right

MA 413 She um don't want um you know um she's friendly
 Mark 414 She's friendly
 MA 414 Yah
 Mark 415 Mm
 MA 415 You know um she don't want to go to leave mark
 Mark 416 Mm
 MA 416 You know
 Mark 417 Right
 MA 417 She I don't she's been crying
 Mark 418 Right
 MA 418 (laughs)
 Mark 419 What do you mean when you say she's friendly
 MA 419 She's friendly she's a little bit chatterbox
 Mark 420 Yeah she is a little bit of a chatterbox yeah
 MA 420 (laughs) how do you know
 Mark 421 I know Corrina she is a bit of a chatterbox yeah
 MA 421 You know well she little bit chatter box I can
 Mark 422 Mmhm
 MA 422 Tell things what's going on with me
 Mark 423 Mm she could tell what was going on
 MA 423 Going on yeah
 Mark 424 How did she do that
 MA 424 Oh um tal talk abou talk about me talk everyone
 Mark 425 Mm
 MA 425 And understand
 Mark 426 Right. She understood she talked to you she talked to others she understood
 MA 426 Yeah
 Mark 427 So she was kind of friendly she understood she listened to you
 MA 427 Ay
 Mark 428 Mm
 MA 428 She understand me
 Mark 429 Mm good
 MA 429 Yeah. She have got short hair now
 Mark 430 Yes
 MA 430 (laughs)
 Mark 431 (laughs)
 MA 431 Go on next question
 Mark 432 Next question okay does it feel like I'm asking you lots of questions
 MA 432 No no I'm not bored not yet
 Mark 433 Okay. You're not bored yet. Okay that's good. I'm glad you're not bored yet. Do tell me if you do get bored
 MA 433 I'm worried about you that's all
 Mark 434 No you don't need why are you worried about me
 MA 434 Oh
 Mark 435 Why are you worried about me
 MA 435 Its ge it get its getting too dark

Mark 436 Okay but I've got a car and I've got lights and I'll be fine. Um what else do I need to ask you we've jumped around a little bit but let's just think what we haven't talked about. When you get a bit panicky now does it feel different to how it did before you met Corrina. Does it feel the same or does it feel different

MA 436 Different

Mark 437 Can you explain how it feels different

MA 437 Oh uh my conf is its gone done it's alright

Mark 438 It's gone down its alright

MA 438 Ay

Mark 439 Uh are you try. Okay. So you're not as panic is that what you're saying you're not as panicky

MA 439 Panic yeah

Mark 440 You're less panicky

MA 440 Yeah not panicking nothing

Mark 441 Mm

MA 441 She come round

Mark 442 Mm

MA 442 I don't get no panic

Mark 443 Okay so you don't get panicked when she comes round

MA 443 Come round no

Mark 444 I'm just thinking about the rest of the time when Corrina's not about um do you still panic as much as you used to or less than you used to or more than you used to

MA 444 No not really

Mark 445 No not really?

MA 445 I first met her little bit nervous

Mark 446 Mm

MA 446 Now now um

Mark 447 Mm

MA 447 The second one that's alright

Mark 448 Right okay what about if you meet other people

MA 448 I get I get tense up quick

Mark 449 Do you think you still get as tense now if you meet someone else as you would have done if you hadn't met Corrina

MA 449 Ay

Mark 450 Mm okay okay there's a little bit of shaking there isn't there not a lot I think that's quite good I'm asking you lots of funny questions I'm not surprised that

MA 450 That's alright

Mark 451 ... if you're feeling anx if you are feeling a bit panicky now what sort of things

MA 451 Don't think about it don't think about it

Mark 452 Right

MA 452 'at make it worse

Mark 453 Mm

MA 453 'at make it um think about it at make it worse

Mark 454 Right
 MA 454 And I cool it cool it down cool with deep breath
 Mark 455 Right So instead of thinking about it you take deep breaths
 MA 455 Deep breaths
 Mark 456 And what happens when you do that
 MA 456 Deep deep broo er bre bre through don't
 Mark 457 Mm
 MA 457 (demonstrates deep breathing) like that Mark
 Mark 458 yeah
 MA 458 And tummy in
 Mark 459 Yeah
 MA 459 Ya know like that
 Mark 460 Right okay
 MA 460 You know uh next question
 Mark 461 Okay next question... is there anything we're going to talk about some
 other things still we haven't finished by any means but are there any other
 things that you can remember from the therapy that you did with Corrina
 that you thought were really good
 MA 461 Walking
 Mark 462 Mm
 MA 462 Walking you know I walk I walking up there I do it myself
 Mark 463 Mm
 MA 463 'at's a bit hard for me walking that's it
 Mark 464 Mm
 MA 464 Meant go crossing over
 Mark 465 Mm
 MA 465 I'm like walking not on the ro on dere I get tense up
 Mark 466 Mm
 MA 466 I go up by boundary I get tense up
 Mark 467 Mm
 MA 467 That's load of ca load of cars there
 Mark 468 Yeah yeah it's a busy road isn't it
 MA 468 busy ro uh yeah
 Mark 469 Mm okay. Is there anything e when Corrina was with you when she came
 into the house and sat with you di did you work in here?
 MA 469 Uh what
 Mark 470 In this room? Yeah okay. What other things did she talk about with you or
 help you with
 MA 470 I can't remember now
 Mark 471 Mm is there anything else you can remember she did
 MA 471 Um uh the make the um the tab that thing I've got
 Mark 472 Mm
 MA 472 Yeah she went on it you know
 Mark 473 Yeah
 MA 473 And said want a tee lea cheerleaders on my there she she done it for me
 Mark 474 Right
 MA 474 And she put the

Mark 475 Mm
 MA 475 You know she put it on there
 Mark 476 Right
 MA 476 Get all the things on
 Mark 477 Okay what tell me about the cheerleaders then and what is it about cheerleaders
 MA 477 Well I like em I do
 Mark 478 You like them
 MA 478 You know I like em exercise
 Mark 479 Mm
 MA 479 You know they do their exercise
 Mark 480 Mm
 MA 480 You know I like like that
 Mark 481 Yeah
 MA 481 You know
 Mark 482 Yeah okay
 MA 482 And sometimes they make you laugh they make you laugh sometimes
 Mark 483 Mm
 MA 483 You know she been uh been helping her do cheerleaders
 Mark 484 Mm
 MA 484 I been helping her
 Mark 485 Yeah
 MA 485 She like my dancing
 Mark 486 Did she
 MA 486 Yeah
 Mark 487 Did she join in
 MA 487 Ay
 Mark 488 Yeah did she dance as well
 MA 488 Yeah
 Mark 489 Okay so how wha what did she what was what was the point of the cheerleaders why were you looking at Cheerleaders together
 MA 489 That's my that's my hobby
 Mark 490 It's your hobby
 MA 490 Eh I like um I like that exercise so I do I like I like that I like exercise
 Mark 491 Mm
 MA 491 And I like that
 Mark 492 Mm
 MA 492 Uh you know I do
 Mark 493 Right so what was the cos she's put the cheerleaders down on your piece of paper I saw there
 MA 493 Uh twice
 Mark 494 Yeah um how were the cheerleaders what was the point
 MA 494 She
 Mark 495 She's think she's put them on there because I guess she thinks they can help you with your with your feeling panicky how do they help you with your feeling panicky
 MA 495 Ah I turn it off n I go n show you something

Mark 496 Well can we is it okay to leave it running yeah?
 MA 496 Yeah
 Mark 497 Yeah?
 MA 497 I got something up there to um she done for me
 Mark 498 Well when we've finished talking shall we go and see?
 MA 498 Yeah yeah
 Mark 499 Can we finish the talking first is that OK? Yeah? Um yeah I was asking I'm not sure the cheerleaders what have they got how do they help you with feeling panicky what do you do
 MA 499 Um she um I can understand uh cheerleaders are help me
 Mark 500 Cheerleaders will help me
 MA 500 Help you yeah I know she
 Mark 501 Right
 MA 501 I got a card photo in there got the words on there
 Mark 502 Right so the cheerleaders will help you
 MA 502 Help me yeah
 Mark 503 Yeah how will they help you
 MA 503 If they talk about it
 Mark 504 They talk about it
 MA 504 Uh
 Mark 505 Mm so do cheerleaders what sort of
 MA 505 I can do
 Mark 506 Are cheerlea what sort of people are cheerleaders what would they what would they be like if you needed some help how would they help you
 MA 506 Help me get better
 Mark 507 They'd help you get better
 MA 507 Ah
 Mark 508 Mm
 MA 508 Get better you know
 Mark 509 Mm how would they help me understand how they would make you get better
 MA 509 They do pompoms and make the words out
 Mark 510 Right they do pompoms and make out the words
 MA 510 Words yeah
 Mark 511 Right okay
 MA 511 That's why I like em
 Mark 512 Right okay
 MA 512 Oh uh so I like em I like their pom poms
 Mark 513 Mm okay I kind of understand so they're using the pom poms and they're making sha making like word shapes n things yeah. OK what words would they make for you
 MA 513 Well 'at's alsorts
 Mark 514 Yeah? They can make all sorts of words
 MA 514 Uh
 Mark 515 Are there any special words they would make they would make for you if you were feeling panicky

MA 515 Uh 'ang on she done everything ... you see I can't find it not that one... that is look that is you've got now

Mark 516 Right oh this is what they would do is it

MA 516 Ay um do like that

Mark 517 Yeah so they do the M it's up to me. I can set the pace. This is very good. C carestaff with help me. H help me stay calm. A always be kind. E do my relaxation exercises. L Let me decide. So they spell out Michael

MA 517 Uh

Mark 518 Oh OK

MA 518 Uh that that help me

Mark 519 Right so when do you use this how when do you when do you look at that

MA 519 Err like um morning times

Mark 520 Morning times

MA 520 Ay

Mark 521 Okay when you look at it what's that what's it like

MA 521 That's alright

Mark 522 Mm how does it help you to feel when you look at it

MA 522 Little bit bit relax

Mark 523 bit relaxed how do you know when you're feeling relaxed

MA 523 Um I'm relaxed now

Mark 524 Right okay

MA 524 I'm calmed down

Mark 525 Yeah how do you know that

MA 525 I ain't shake I ain't shaking at all

Mark 526 Right you're not shaking at all

MA 526 No

Mark 527 Are there any other ways you know that you're relaxed

MA 527 Er I ain't nervous at all

Mark 528 You're not nervous. OK what's it like to be nervous

MA 528 Terrible you can't do nothing

Mark 529 Mm

MA 529 It get tense up quick

Mark 530 Right So you get all tense and

MA 530 Uh

Mark 531 Okay. so we've been talking about the cheerleaders I'm getting a bit I'm getting a bit lost so let me try and remember where we're at

MA 531 (laughs)

Mark 532 The cheerleaders. So you like what you like about it is all the pompoms

MA 532 Pompom yeah

Mark 533 And all the letter shapes and Corrina asked you to imagine making the letter shapes

MA 533 Right

Mark 534 For your name for Michael

MA 534 Uh

Mark 535 And she worked out all these things they could say

MA 535 Uh

Mark 536 While they were making those letter shapes. You look at it and it helps you to be
 MA 536 Yeah
 Mark 537 Calm and
 MA 537 Calm
 Mark 538 Relaxed rather than n nervous and panicky
 MA 538 Uh
 Mark 539 Mm do you ever look at it any other times apart from in the morning
 MA 539 If sometimes I do sometime don't
 Mark 540 Mm what time when what times do you look at it
 MA 540 Don't matter which time
 Mark 541 Mm
 MA 541 You know so sometimes I do sometimes I don't
 Mark 542 Mm Okay
 MA 542 You know
 Mark 543 Whenever you look at it does it make you feel better or
 MA 543 Better
 Mark 544 Yeah does it ever make you are there ever any times when it hasn't made you feel better
 MA 544 I make er this one's better
 Mark 545 It makes you feel better
 MA 545 Ay
 Mark 546 Okay... so now can we ask er one more set of questions to ask you
 MA 546 Okay
 Mark 547 And these are about self-compassion about feeling warmth towards yourself
 MA 547 Warm
 Mark 548 Yeah feeling feeling good about yourself. Did she talk to you about self-compassion
 MA 548 Warm place
 Mark 549 Warm place yeah
 MA 549 (laughs)
 Mark 550 She's drawn a palm tree in the sun very good alright she talked to you about warm places and feeling warm and feeling good what did
 MA 550 She worri about she worria bout me I get cold outside
 Mark 551 Right
 MA 551 That's why she put down
 Mark 552 Yeah okay did she talk to you about feeling good about yourself
 MA 552 Ay
 Mark 553 Yeah what did she have to talk about
 MA 553 It was alsorts
 Mark 554 Can you tell me some of the things she talked about
 MA 554 Oh to go on the bea(ch) um on there
 Mark 555 Yeah
 MA 555 Trees you know
 Mark 556 Yeah
 MA 556 This that's a that's exercise

Mark 557 Yeah okay doing your exercise tensing up and relaxing exercises yeah
 MA 557 That's uh everything on there that's everything on there
 Mark 558 Okay so these are all the things you can do to stay calm so deep breaths
 imagining a warm calm place. Tensing and relaxing all your muscles
 MA 558 Uh
 Mark 559 Remembering your cheerleaders. Um and then she's also put some stuff
 about what other people can do like they can listen to you
 MA 559 Eh
 Mark 560 They can let you have your own ideas and they be kind and supportive
 MA 560 Ay
 Mark 561 So she's done a lot with you hasn't she
 MA 561 Ay
 Mark 562 Yeah okay so I want to know about, how, I want to know about whether
 she talked to you about feeling feeling good about yourself
 MA 562 Eh
 Mark 563 And you feeling good about who you are
 MA 563 Yeah
 Mark 564 Did she talk to you about anything like that
 MA 564 No
 Mark 565 No? did she help you think about whether other people might feel like you
 do
 MA 565 No
 Mark 566 Did she ever talk to you about whether anyone else ever felt panicky?
 MA 566 No No
 Mark 567 No
 MA 567 She just talked about meself
 Mark 568 She just talked about you
 MA 568 Ay
 Mark 569 Mm okay did she ever help you not worry so much if you were getting
 panicky
 MA 569 No I'm not worried at all
 Mark 570 You're not worried at all
 MA 570 No
 Mark 571 Why aren't you worried at all
 MA 571 I ain't worried 'bout nothing now not yet
 Mark 572 No? you're not worried about anything
 MA 572 Not yet
 Mark 573 Not yet okay. What things do worry you
 MA 573 I go out go out
 Mark 574 Mm
 MA 574 Never get get tense up a little bit
 Mark 575 Mm
 MA 575 Ah you know is all
 Mark 576 Mm
 MA 576 'at's it
 Mark 577 Mm so going out and getting tensed up worries you
 MA 577 Uh

Mark 578 Um I wonder if Corrina helped you um be less upset about be less worried
 about how about getting upset
 MA 578 I do get upset sometimes
 Mark 579 Mm
 MA 579 Not often
 Mark 580 Mm
 MA 580 I don't I don't talk about it or I I belt up I do
 Mark 581 Mm
 MA 581 If something 'set me I don't tell no one I don't tell me mum sometimes
 Mark 582 Mm why do you keep it to yourself
 MA 582 You know I get I don't like people get upset
 Mark 583 Mm
 MA 583 You know that bob it up sometime
 Mark 584 Mm
 MA 584 You get more anxious
 Mark 585 Mm
 MA 585 You know sometimes
 Mark 586 Mm Sometimes you get more anxious when you tell other people about it
 MA 586 Ah
 Mark 587 Mm why do you think that is
 MA 587 I don't know why
 Mark 588 Mm
 MA 588 I don't know why Mark I don't know why
 Mark 589 Mm okay but you do sometimes
 MA 589 Sometimes
 Mark 590 Yeah does that mean that sometimes its better just to keep things to
 yourself
 MA 590 Self yeah
 Mark 591 Mm Do you think other people feel the same way sometimes
 MA 591 Yeah sometimes
 Mark 592 Mm do you think there are ever times when other people think it's good to
 talk about things
 MA 592 Yeah talk about it
 Mark 593 Mm
 MA 593 Talk about it
 Mark 594 Who can you talk about things to
 MA 594 Mum
 Mark 595 Mum yeah
 MA 595 Family
 Mark 596 Family yeah
 MA 596 The people
 Mark 597 Okay
 MA 597 You know I get nervous other people
 Mark 598 Mm
 MA 598 'at's sometimes I got beat up years ago years ago I got beat up in the city
 Mark 599 Okay you got beat up in the city
 MA 599 City yeah now I'm a bit nervous of people

| | |
|----------|---|
| Mark 600 | Mm |
| MA 600 | I still are you know |
| Mark 601 | Mm |
| MA 601 | You know |
| Mark 602 | You're still nervous of people |
| MA 602 | People yeah like childrens |
| Mark 603 | Mm |
| MA 603 | Some walk past a bit nervous |
| Mark 604 | mm. must be very difficult |
| MA 604 | It's difficult yeah |
| Mark 605 | Mm |
| MA 605 | Yeah I still |
| Mark 606 | Do you think you're any more |
| MA 606 | I get I get I get a bit a little bit bet better |
| Mark 607 | You're getting a little bit better |
| MA 607 | Yeah |
| Mark 608 | Why do you think that is |
| MA 608 | I getting getting get a little bit comst getting getting better walking |
| Mark 609 | Mm |
| MA 609 | And erm I talk talk more people now |
| Mark 610 | Right |
| MA 610 | I used to |
| Mark 611 | Mm |
| MA 611 | Walking I say hello people |
| Mark 612 | Mm |
| MA 612 | And of like that |
| Mark 613 | Mm. what's that like to do |
| MA 613 | That's alright |
| Mark 614 | That's alright |
| MA 614 | Yeah |
| Mark 615 | What do you think why do you think that's change has happened |
| MA 615 | I don't know |
| Mark 616 | Mm |
| MA 616 | I don't I don't know |
| Mark 617 | And how long do you think that change has been happening for |
| MA 617 | Not not long |
| Mark 618 | Mm |
| MA 618 | Not long |
| Mark 619 | Do you think it's anything to do with Corrina |
| MA 619 | I don't know |
| Mark 620 | No |
| MA 620 | Come back we show little bit |
| Mark 621 | Sorry? |
| MA 621 | Come back a bit out of me shell you know |
| Mark 622 | Oh you come out your shell a bit |
| MA 622 | (laughs) you that what I mean |

Mark 623 Oh right yeah I do know well I think I know what you mean you tell me what you mean

MA 623 Well come out my shell you know you come out you get you get uh get better

Mark 624 Mm

MA 624 Out of the shell you know that that open

Mark 625 Yeah so you felt like you were like a little closed shell

MA 625 Ay

Mark 626 And now you feel like it's a bit open

MA 626 Little bit open

Mark 627 Mm is that a good thing or a bad thing

MA 627 Good thing

Mark 628 That's a good thing okay. How do you think the sh what do you think made the shell open a little bit

MA 628 I talk more I talk more uh I talk more to ki talking people

Mark 629 Mm

MA 629 You know I talk more peo people out outside I talk too much maybe

Mark 630 (laughs)

MA 630 (laughs) I do

Mark 631 You talk too much

MA 631 You outside I can't stop me talking

Mark 632 Okay you can't stop yourself talking

MA 632 No

Mark 633 You're talking really well today actually you are talking a lot so you're doing really well

MA 633 I talk too much

Mark 634 Mm

MA 634 I'm indoors I'm real quiet

Mark 635 Mm

MA 635 Um I'm outside little bit chatterbox outside

Mark 636 mm you're a little bit of a chatterbox outside

MA 636 Aye

Mark 637 Mm

MA 637 You know something Mark, you cheer me up

Mark 638 Have I? How have I done that

MA 638 My fa see my face

Mark 639 I can see that your cheer more cheerful yeah but how have I done that

MA 639 I don't know

Mark 640 Mm

MA 640 Talking about it

Mark 641 Talking about it mm

MA 641 You know

Mark 642 mm. You seem calmer than when we started

MA 642 (laughs)

Mark 643 People are often a bit nervous when you start these sorts of con in interviews but they calm down and you think you have calmed down now haven't you

MA 643 Ay
Mark 644 Mm. I'm still interested in this shell thing. You've said that you feel like you're a shell that's just opened up a bit
MA 644 Little bit like that like that
Mark 645 Yeah okay just a little bit just just
MA 645 Like that
Mark 646 Yeah not fully open but just a bit open
MA 646 Bit yeah
Mark 647 And you you think that's is that the work you've done with Corrina you think
MA 647 Corrina yeah
Mark 648 Can you tell me what you think the things are she did that helped you be open
MA 648 She helped she uh she talk talk talk sense you know talk more clearer
Mark 649 Right
MA 649 She's you know she ain't bo she ain't bossy at all
Mark 650 Right
MA 650 You know she like that
Mark 651 Mm
MA 651 I get on alright
Mark 652 You got on alright with her
MA 652 Ay
Mark 653 She wasn't bossy or anything
MA 653 No
Mark 654 Okay
MA 654 Um I calm down I calmed down she calmed down you know I relax little bit
Mark 655 She helped you to calm down and relax a little bit
MA 655 Ah that's me you know
Mark 656 Right okay so she wasn't bossy you were able to calm down and relax a little bit
MA 656 Bit yeah
Mark 657 Mm. and the shell opened a bit
MA 657 A little bit yeah
Mark 658 Right what was it like to open that shell up with C with Corrina
MA 658 I'm pleased little bit little bit pleased
Mark 659 You're pleased okay what was it like to do it though to kind of be a bit more open with her and a bit
MA 659 I'm ha Happy
Mark 660 You're happy yeah
MA 660 Ay
Mark 661 The thing with the shell being open a bit I wonder what's going to happen in the future are you gonna try and open it some more
MA 661 Some more
Mark 662 Or close it again
MA 662 No uh kee kee keep practising
Mark 663 Keep practising
MA 663 Ah

Mark 664 Mm
 MA 664 She uh she help me a lot you know that's why it's a little bit open she done it
 Mark 665 Mm
 MA 665 She has understand me
 Mark 666 Right she understood you
 MA 666 Yeah
 Mark 667 She helped you open it
 MA 667 Ay
 Mark 668 But now you've gotta keep practising
 MA 668 Keep practising
 Mark 669 And it'll open more
 MA 669 More yeah
 Mark 670 So what's the future hold for you do you think
 MA 670 Get get better
 Mark 671 Get better
 MA 671 Get better you know
 Mark 672 Mm how will you know when you're getting better
 MA 672 Uh by um by bit changed
 Mark 673 Mm
 MA 673 By 'at's easy to tell a bit tense up
 Mark 674 Mm
 MA 674 Tense up sometimes
 Mark 675 Mm
 MA 675 Thought about it you know and like that Mark
 Mark 676 Mm so it'll be in your body that you'll know
 MA 676 I know I got the hiccups (coughs)
 Mark 677 You'll know in your okay so you'll know in your body that you're getting better
 MA 677 Yeah
 Mark 678 Cos you won't get that sort of tense up
 MA 678 Tense up
 Mark 679 Okay
 MA 679 You you get tense up right ere
 Mark 680 Mm
 MA 680 You know right that hurt sometime
 Mark 681 Right
 MA 681 I get get it there
 Mark 682 Okay so you're describing in your chest
 MA 682 Ay
 Mark 683 You won't get it in the same way it won't hurt sometimes
 MA 683 Sometimes it do sometimes it don't
 Mark 684 Mm
 MA 684 I get tense up my heart go beat hard
 Mark 685 Your heart beats hard
 MA 685 You know
 Mark 686 Okay, how else will you know that you're getting better

MA 686 Uh relax you know not go down
 Mark 687 Mm
 MA 687 Not go high not go down
 Mark 688 Right
 MA 688 Now 'at's 'at's normal
 Mark 689 Mm
 MA 689 'at's normal
 Mark 690 right so it fit
 MA 690 'at's my clock
 Mark 691 Oh that's your clock is it I wondered what that was
 MA 691 (laughs)
 Mark 692 Um so your heart won't go high it won't go low it'll just be normal
 MA 692 Normal yeah
 Mark 693 mm okay so you'll know in your body that you're getting better. I wonder if
 there's any other ways you'll know that you're getting better
 MA 693 Um err crossing er crossing uh you know your car is
 Mark 694 Mm
 MA 694 'at's bit hard um bit har um this week's I can't cross the paths you know
 like your car is
 Mark 695 Yeah
 MA 695 I can't walk I can't walk properly near the car I need someone help me
 Mark 696 Right
 MA 696 Uh um I been alright so far this week is bad you know I can't do it at all I
 need someone hel help me
 Mark 697 Why is this week bad
 MA 697 I don't know why you know I gone down a little bit
 Mark 698 You gone down a little bit
 MA 698 You know I get I used to walk near the car
 Mark 699 Mm
 MA 699 Now it's gone down little bit I can't do it
 Mark 700 Mm
 MA 700 That's some some help help me crossing over
 Mark 701 Mm
 MA 701 Near the car
 Mark 702 Mm
 MA 702 Sometimes I do it you know I like um I went I went um the uh doctors you
 know uh help wi you know Richard
 Mark 703 Mm
 MA 703 He's a good helper he help me a lot he do
 Mark 704 Mm
 MA 704 He do you he help me help me
 Mark 705 Right
 MA 705 You know he's been training course
 Mark 706 Right
 MA 706 About it
 Mark 707 Yeah

MA 707 You know
 Mark 708 Richard is your MENCAP worker isn't he
 MA 708 Ay
 Mark 709 Yeah
 MA 709 You know he's been on a on a tra on a course
 Mark 710 Mm
 MA 710 About it
 Mark 711 Okay
 MA 711 You know um a bit get tense up I can't can't do it you know uh hold it
 Mark 712 Mm
 MA 712 Hold it t-shirt
 Mark 713 Right
 MA 713 Don't hold it like that
 Mark 714 Not on your arm
 MA 714 Like that um you know uh hold my t-shirt
 Mark 715 Right
 MA 715 I might might fall over
 Mark 716 Right okay
 MA 716 You know
 Mark 717 Mm this week's been a bit harder
 MA 717 Bit harder
 Mark 718 So what's that shell doing is it about that shell is that shell a bit more open
 or a bit more closed this week do you think
 MA 718 'at's little bit like that
 Mark 719 Right what was it last week
 MA 719 Uh that was still the same
 Mark 720 Still the same so the shell's not gone more open or closed
 MA 720 Right no not yet
 Mark 721 Okay what do you think it would take for the shell to fully open
 MA 721 Get better
 Mark 722 Yeah how
 MA 722 Don't think about it
 Mark 723 Don't think about it don't think about what exactly
 MA 723 Don't think about it and make it worse
 Mark 724 Mm okay so don't don't get don't get stuck thinking about it
 MA 724 Stuck yeah
 Mark 725 Mm okay
 MA 725 Um oh yeah um my back's been playing up a little bit too
 Mark 726 Oh you've got some back problems have you
 MA 726 Ah
 Mark 727 Mm okay I'm just checking through and see if we've asked all the questions
 is there anything else you'd want to say
 MA 727 Not not really
 Mark 728 If someone if you knew someone who was feeling a bit anxious a bit
 worried a bit panicky
 MA 728 Uh

Mark 729 What would you say to them about all of the stuff you've done with Corrina
 how would you describe it to them
 MA 729 I'd talk about it
 Mark 730 Yeah what would you say
 MA 730 Uh she done wonderful
 Mark 731 Mm
 MA 731 You know e understand me you know like that
 Mark 732 Mm
 MA 732 You know that's it
 Mark 733 Is there anything else you would say do you think
 MA 733 No 'at's it
 Mark 734 Okay how would you describe the work that you did together what would
 you want to say about that
 MA 734 Uh I like it
 Mark 735 You like it
 MA 735 Yeah
 Mark 736 Mm
 MA 736 I like it
 Mark 737 Okay so she's she's she really understands you and you really liked the
 work
 MA 737 Ay
 Mark 738 Was there stuff that was hard to do
 MA 738 Little bit a little bit easy
 Mark 739 Mm
 MA 739 Little bit easy
 Mark 740 Right was there ever any stuff that you thought was difficult
 MA 740 No not really
 Mark 741 No
 MA 741 No
 Mark 742 Mm And what how would you describe to this friend this friend who you
 might have who was feeling a bit panicky how would you say it's changed
 you to do this
 MA 742 I get little bit panic um it's alright little bit
 Mark 743 It's alright a little bit now
 MA 743 Ay
 Mark 744 Mm... would you would you want to say anything about self-compassion
 and feeling good about yourself
 MA 744 I'm good
 Mark 745 Yeah do you think Corrina helped you with that at all
 MA 745 Ay
 Mark 746 How do you think she helped you with that
 MA 746 Good
 Mark 747 Mm do you think she do you think anything she did helped you feel like you
 were a better person
 MA 747 A better per per a good person
 Mark 748 Mm
 MA 748 Good person you know

Mark 749 Mm do you think she helped you change how you feel about yourself
 MA 749 There was change she she change a lot
 Mark 750 Mm what about how you feel about who you are do you think you feel
 better about yourself or
 MA 750 A little bit
 Mark 751 Mm can you describe what that
 MA 751 Little bit
 Mark 752 How that is
 MA 752 A little bit like that
 Mark 753 A little bit like what sorry
 MA 753 I can't I don't know I er um I I like her you know
 Mark 754 Mm
 MA 754 She helped me like that
 Mark 755 Right you like her okay yeah okay
 MA 755 Not like that Ma you know
 Mark 756 Oh I didn't think you meant li no I know what you meant she's a nice
 person
 MA 756 You know
 Mark 757 Yeah she's a nice person and I think that was what you meant wasn't it...
 Do you think as you worked with her that
 MA 757 She's ca she's calm she calm Mark
 Mark 758 Right yeah
 MA 758 She calm she listen you know you got troubles like I had I had a load of
 trouble I had she phoned not phoned up um I been crying she um on the
 'puter in a white cap she put word on there
 Mark 759 Right
 MA 759 I not got to not got told off um
 Mark 760 Right
 MA 760 You know I got I'm going too much
 Mark 761 Right you were trying to do too much
 MA 761 I doing too much so she write a letter
 Mark 762 Mm
 MA 762 Mark she write it down
 Mark 763 What's it li so you were trying did she help you to realise you were trying to
 do too much
 MA 763 Oh I er you know I said I'm doing too much
 Mark 764 Mm
 MA 764 And I've um
 Mark 765 And what was it like to say that to her
 MA 765 I said I cry I had a cry I did up the road you know that's up upset me
 Mark 766 Mm
 MA 766 You know like that
 Mark 767 Mm
 MA 767 I'm getting bit
 Mark 768 What di – sorry go on
 MA 768 I'm getting little bit better
 Mark 769 Yeah. You're getting a little bit better

MA 769 Better yeah
 Mark 770 Mm what was it like when Corrina kinda said it's okay to do less
 MA 770 Less you know 'at's me what do less
 Mark 771 Mm
 MA 771 No one can't force me do it
 Mark 772 Mm
 MA 772 N No No one can't force me
 Mark 773 Mm
 MA 773 At all
 Mark 774 No on can force you to do it
 MA 774 Do it yeah no
 Mark 775 Mm so what was it like when she kind of talked to you about that
 MA 775 She's calm she's calm
 Mark 776 Yeah
 MA 776 Now 'at's back to back to normal
 Mark 777 Back to normal what's normal like
 MA 777 'at's alright
 Mark 778 Mm how do you know it's back to normal
 MA 778 I don't shake don't shake or nothing
 Mark 779 Right you don't shake or anything mm is it nice that you don't shake or is it
 do you kind of miss it
 MA 779 I ha I hate it
 Mark 780 You hate shaking or you
 MA 780 Yeah you know I ha ha hate it sometime
 Mark 781 Mm why do you hate shaking
 MA 781 Er I get get tense up quick
 Mark 782 Mm
 MA 782 You know. You can't do things things
 Mark 783 Mm
 MA 783 Can't walk properly
 Mark 784 Right okay and are you less like that now or more
 MA 784 Yeah um more mo more I think
 Mark 785 More uh so help me understand this a little bit you're more tense now or
 you feel better now
 MA 785 A bit better now
 Mark 786 You feel a bit better now
 MA 786 Sorry Mark
 Mark 787 That's alright I'm just trying to make sure I unders see what you're saying.
 You feel a bit better now, wh again why is that what is it that helps you to
 feel better
 MA 787 Better get uh um night times uh night times 'at's good
 Mark 788 Night times are good
 MA 788 Good and uh mor mornings bit higher
 Mark 789 Mm
 MA 789 You get tense up quick
 Mark 790 Okay what happens when you get tensed up quick now
 MA 790 You um sh bit sh bit shaky you know

Mark 791 Mm uh how the work that you did with Corrina wha how has that helped
you when you start feeling a bit tense

MA 791 A deep a deep breath

Mark 792 Deep breaths okay

MA 792 Keep your calm down

Mark 793 Yeah

MA 793 Cal calm down

Mark 794 Mm okay so all that stuff has helped you

MA 794 Ay

Mark 795 Okay. I asked you earlier I'll ask again is there anything else you wanted to
say today or anything else you wanted to say about the work you did

MA 795 No

Mark 796 No?

MA 796 I'm a I'm happy

Mark 797 You're happy okay shall we stop this here then

MA 797 Yeah

Mark 798 Alright then I'll turn the tape off

Appendix 10.

Transcript Two – AW

- Mark 1 Alright so that's working. So, um like I've said what I've got is a basically we just sit and have a chat for a while now if that's okay with you
- AW 1 Fine yeah
- Mark 2 And I've got a load of questions to ask you about everything that happened
- AW 2 Yeah fine
- Mark 3 Yeah okay. So to start with, I mean tell me what your therapy was like. Tell me what it was like doing all of that
- AW 3 Um what with Corrina
- Mark 4 Yeah
- AW 4 Um she's very helpful and er I done everything what she asked me to do and er I think she done a good job
- Mark 5 I'll just turn that round a little bit. You think she did a good job
- AW 5 Yeah
- Mark 6 Okay what makes you think feel that way what makes you think it was a good job
- AW 6 Um cos I done I had er all that like in the past and er I seen different people and she she's the best er one I've seen. Since 1993 and the centre when I see the sta um governors' Wednesday they said that how much better I looked and I'm doing things a bit more yeah
- Mark 7 So people seem to think you're looking a lot better
- AW 7 Yeah... I'm sort of going in doing um what they tell me to do when before all I wanted to do was go to sleep but I ain't done that since I joined these new groups. And I wouldn't be going like when we get our shopping when we go out and er I get it and then walk back again and we can sometimes go out like in the afternoon where I didn't do that before and I done that a couple of times.
- Mark 8 What is it do you think that's made that difference for you
- AW 8 Um having me hysterectomy done what uh helped me a bit. Mm had it done last September. September the fifth had that done
- Mark 9 And what about your do you think the work with Corrina helped you
- AW 9 Yes that did yeah
- Mark 10 Can you tell me how that you think that might have helped you
- AW 10 Um sort of talk about um cos I was bullied last year and er she sort of helped me out what to do wi with that girl and er and uh now cos I'm next door all day I don't er hardly see anybody uh got different people in the group so a lot better
- Mark 11 What was it like talking to Corrina about that
- AW 11 Fine yeah that's fine yeah I did um when she come down Monday she come down
- Mark 12 Right
- AW 12 And uh she had to see someone else and uh she asked me how I was doing and uh all that sort of thing
- Mark 13 What do you think um where the best bits about working with Corrina

AW 13 About making my memory box with all the stuff in and er I say giving me tips how what to do and uh just sort of basically sort of all different things what she done

Mark 14 How did you feel about Corrina coming round regularly

AW 14 Er good I I missed her the last couple of weeks I say to mum I didn't sort of want to like go backwards n do all that sort of thing but you know I have missed her talking to her yeah that have sort of cleared me head a bit

Mark 15 Mm it has cleared your head. Can you tell me what you mean by that try and explain that for me

AW 15 Uh sort of like um when she talk talk to me about when people die and uh and um and she want to know what I wanted to write in these letters and er I don't know. I have missed talking to her

Mark 16 Okay what were the things that were there any things you found not so good you found harder about the work

AW 16 Um at first I used to find hard talking er about me sister and sort of like as time went on that sort of made it a bit easier

Mark 17 Okay and what was that like for you finding it getting easier to talk about it

AW 17 Um sort of just to talk talk about my sister and er and then helped me to talk talk about my friend Janet tried to sort of help me more mm and the centers found that I'm looking a lot better even uh the girl from the trust said that I looked much better

Mark 18 How do you feel in yourself

AW 18 A lot better yeah

Mark 19 Can you describe how

AW 19 Um sort of coming off me diazepam and uh sort of just do things cos I gone off me cross stitching for um er little while now I got back into doing it again. I do all different things and

Mark 20 Um I'm wondering how you feel different inside you

AW 20 Um not so sick I don't have me head don't feel so heavy I'm able to do what I ain't done before

Mark 21 Can you tell me about that what's about things you haven't done before

AW 21 Um sort of don't know I still have to take it easy haven't even been six months yet

Mark 22 Mm ok so your work with Corrina you've told me about what you found good and what you found difficult. Were there any bits of it you found really easy.

AW 22 mm... I don't know um when when um I sort of stopped putting my teeth in after I had my operation done and then er that sort of got a bit harder and harder to and she told me what to do and um and that was a lot lot easier yeah and now I'm starting eating little bits and pieces. Er eating in a group still was (*unclear*) and I didn't do that before and that so

Mark 23 What do you think why do you think you started being able to eat in the group what do you think that was about

AW 23 Um I think cos that's all different people were before that was just like people like on and on and on but now in two groups it's all different people

Mark 24 Do you think there was anything different about you that helped you to do that

AW 24 Being comfortable

Mark 25 Being comfortable

AW 25 Yeah

Mark 26 What do you mean by that

AW 26 Um sort of where I can eat eat eat in front of people and that

Mark 27 mm. And what changed for you to make you comfortable

AW 27 Um the staff are giving me lot of praises for what I what I what I'm doing

Mark 28 Mm hm do you think you felt do you think there was anything about the way you were thinking about it or feeling about it that was different

AW 28 No.... mm

Mark 29 Okay so the work that you did with Corrina, all that time that you spent with her, do you think it helped you

AW 29 Yes that did yeah

Mark 30 How so how did it help you

AW 30 Um I in't had them er panic attacks since I started er bit er talking to her and I ain't had that horrible feeling in my legs mm I get it in my leg

Mark 31 So no panic attacks and no feelings in your legs

AW 31 No

Mark 32 How do what do you think what's that about how did that change for you

AW 32 Um just talking about death and er all different things

Mark 33 Can you remember any things that you did together that really helped you know you mentioned talking about death. I wonder what else do you think really helped

AW 33 Um tell me to like be calm and... I don't really know

Mark 34 But you remember her telling you to be calm

AW 34 Yeah

Mark 35 Tell me more about that

AW 35 If someone upset me like if say like I'm in a group I don't walk out just uh sit there that's what I been doing... I get on with that girl more I'm a bit better at the minute

Mark 36 mm. how do you find being calm try and explain for me what that means what that's like

AW 36 Um not not cry or nothing like that. I don't know

Mark 37 Yeah it's a difficult question

AW 37 Yeah it is isn't it

Mark 38 What I'm trying to get at is how do you feel differently now how do what inside you know whats going on inside you that's different now to before you met Corrina

AW 38 Um happy

Mark 39 Happy

AW 39 Yeah

Mark 40 Tell me about feeling happy

AW 40 Um like where she always used to write all these uh to show me how to keep calm and write all things down like do drawings and um and that help me when she show me what dra drawings to do like when um go in hospital when I come out of hospital

Mark 41 So she wrote there was lots of things written down and she did some drawings

AW 41 Yeah I think if I didn't see her last year I think I would have been more nervous than what I did do

Mark 42 You'd have been even You'd have been more nervous

AW 42 Yeah

Mark 43 Ok so something she did helped you to feel less nervous

AW 43 Yeah

Mark 44 What do you think that was

AW 44 Just talking to her

Mark 45 Mm. What was it like to talk to her

AW 45 Mm like um calm when she walked in. um just uh sort of miss talking to her a little bit

Mark 46 Yeah sure you told me when you first met you kind of you got nervous with strangers so but you've just said that you felt calm when Corrina was here tell me more about that what did you mean by that

AW 46 Um sorta calm to talk to uh previously when I had counselling before I didn't uh sort of feel that comfortable

Mark 47 What was it like feeling that comfortable with her

AW 47 Just relaxing

Mark 48 Relaxing

AW 48 Yeah.. relaxing n when I say I wasn't even nervous when I went down to the theatre n sort of laid there and just sort of let them get on with it

Mark 49 Would you have do you think you would otherwise have been nervous if you hadn't seen Corrina would you have been nervous

AW 49 I would have been nervous yeah

Mark 50 Mm so whats what was that like to think about what do you think about the fact that you weren't nervous

AW 50 Um that she done a good job with me. Even mum said she did

Mark 51 And what about the job that you did kind of working with Corrina do you think that you did a good job

AW 51 Yeah I did anyway

Mark 52 What do you think you did really well

AW 52 Um sort of doing everything she told me to do like making that memory box was quite good. Put everything in what I got and sort of done everything what she told me to do anyway. People reckon I look a lot better

Mark 53 Mm what do you think about how you look

AW 53 Yeah

Mark 54 Whats it like to kinda feel that you look better

AW 54 Um bit more colour um don't really know

Mark 55 So you feel like you got a bit more colour

AW 55 Yeah I ain't taken my iron tablet any more. I ain't took that for about two months I think that was two months

Mark 56 Is it kind of nice to look to think that you look better and that people are noticing

AW 56 Yeah

Mark 57 What's it like when people notice
 AW 57 Mm sort of happy it is when Trish say I do anyway (smiles) yeah might be cos I'm getting on with things at the centre and mm yeah

Mark 58 So the reason we've did all this work and the reason you met Corrina was that you were getting worried by things. How do you think that's changed since we first met

AW 58 Mm talking talking about things mm talking about death mm..

Mark 59 Do you think you get worried as much as you did before

AW 59 Mm a little bit little bit not so bad

Mark 60 Mm little bit not so bad

AW 60 Yeah

Mark 61 Ok. Does it feel different when you worry now

AW 61 Yeah just sort of try and stay calm if I if I can

Mark 62 How do you do that

AW 62 By take deep breaths. And sort of basically get on with what I gotta do and.. mm (*don't*) really know about that bit

Mark 63 Okay these are difficult questions. So you're worry worrying about things you do you sort of sometimes do sometimes don't. Um would you say when you worry it feels the same as it did before or does it feel not as bad now

AW 63 No still a little bit but not as bad as it was before

Mark 64 Mm how tell me what tell me how, try and explain to me what you mean by that you know how is it different what's changed about how you feel when you worry

AW 64 Since last year? Um sort of basically got everything out instead of keeping it in like talking to people like I talking with Corrina and I also talk to staff at the centre if I'm worried about anything

Mark 65 Yeah ok, so what I'm trying to understand is if you, you're not as worried now as you were before but I wonder if when you're worried it feels the same as it does before or does it feel different now to how it did before

AW 65 Oh sort of half and half

Mark 66 Mm and if you could explain for me what feels different how does worrying now feel different to how it felt in the past

AW 66 Mm I don't know

Mark 67 How does it feel the same

AW 67 Mm not so much

Mark 68 Not so much

AW 68 No ok

Mark 69 So but something about how much you worry has changed because of the time you spent with Corrina

AW 69 Um not some things do with her before I start having counselling. Sort of eased off a bit. Um sort of made it better tricky question that one

Mark 70 Yeah they are tricky questions but we're working it out we're figuring it out. What do you think Corrina did what do you think happened with Corrina that made you worry less

AW 70 Um I like talking to her

Mark 71 What was it about talking to her that helped

AW 71 Um I don't know um sort of getting things off my chest
 Mark 72 I'm wondering what that was like to do you know what was it like being able to talk to Corrina

AW 72 Just tell her like what uh happened like things what had happened, um... sort of made me feel a bit sort of um like I've got things off me chest sort of thing

Mark 73 Okay and how did it feel how did that ch how did it feel having got them off your chest

AW 73 Better

Mark 74 Better

AW 74 Yeah. Much better

Mark 75 Okay I'm thinking about what else you've mentioned about the therapy you've also mentioned um that you wrote some letters and wrote things down

AW 75 Yeah they're there

Mark 76 Which are there what was that like to do

AW 76 Um when she read it back to me one what I done for my sister that sort of made me upset but when she read it again about a week later I was alright about it. And I wrote one for my friend Janet who I wrote one out for yeah that's quite good to do

Mark 77 Mm that was good to do. What was it about it that was good to do

AW 77 Um I knew people done them and just like to put everything like in a box and put it underneath my bed in my bedroom so if I wanted to see anything I just sort of like take the lid off and put and then put the lid back on

Mark 78 Again what was it like doing that memory box with her

AW 78 Mm uh that's made me happy

Mark 79 What was it about it that made you happy

AW 79 Uh finding some photos to put in um necklaces and I got some um like um plate things like with dinosaurs and that on I put them in the box as well and so I've got some photos of my friend Janet in the box and uh I ain't found nothing else to put in there yet

Mark 80 Okay it feels like you said not anything else in there yet is that kind of you thinking that there might be other things to go in there later

AW 80 Yeah I ain't sort of found any more photos not yet so I keep uh sort of having a look and yeah

Mark 81 If you um do you still feel anxious sometimes do you still get worried sometimes

AW 81 Yeah about um what gonna happen to me in the future. Sort of big worry

Mark 82 Mm hm tell me what you mean by that

AW 82 Um sort of being on my own about my carer who come up take me out uh er he said I won't be on my own you don't know do you really sort of gonna happen

Mark 83 Was that something you worried about before meeting with Corrina

AW 83 Yeah

Mark 84 Do you think you worry about it the same, more or less now

AW 84 Um I think more cos I've been having people die dad had a cousin die er last month and um my step auntie's uncle yeah step auntie's mother died uh mum and dad went to the funeral on Wednesday I didn't go so uh I sort of been a bit full on I think, plus we had two members die at the centre last year so that sort of right quick n the other one sort of thing. I don't like death anyway

Mark 85 Do you feel differently about it after your time with Corrina

AW 85 Yeah lot better yeah

Mark 86 Mm how is it different now

AW 86 Um I still think about it but um I only think about it when like if anything happened to someone else or something like that

Mark 87 And how's that different to how was it before then

AW 87 hard. That's getting there but they say that get easier but I don't think it do

Mark 88 mm hm what makes you feel that it's not going to get easier

AW 88 Mm that don't once you've sort of had something happen or keep dying um I said to Corrina I say I don't know why he had to keep take people away and mm if there is one up there I don't know I honestly don't know bit hard question that one

Mark 89 Mm I seem to be asking you a few hard questions today but you're doing really well at answering them. If you were to start worrying about something now, are there any things from the therapy that you would kind of remember to help you

AW 89 Try to stay calm and, there's this anniversary and that what sort of bug me a bit

Mark 90 Mm. Tell me more about this you said stay calm a couple of times now, tell me what you mean by that

AW 90 Um not to get uh cos I ain't had no panic attacks or anything like that m I ain't took no more Diazepam or not since I been talking to Corrina and uh do you know Maggie Parke? Yeah she come round a couple of times and done my budget for me and that's all done and dusted so yeah I got everything I wanted on that so sort of made me feel a bit better

Mark 91 Um I'd like to know more about this thing about keeping calm

AW 91 Mm don't not to like when I'm up at the centre or um I don't know

Mark 92 How did what can you remember about um what how Corrina helped you to think about keeping calm

AW 92 Uh I remember um sort of don't really know

Mark 93 Did she do any things with you any special things with you to help you to practice being calm

AW 93 Um take er like deep breaths and like uh if I go to the centre and come home and then take me teeth out she normally say take five deep breaths and take them out and that's been a lot better

Mark 94 Okay so deep breaths helps you to keep calm can you how d how does it feel like for you to do that what's it like doing the deep breaths

AW 94 I just go (*demonstrates deep breathing*) like that and take five deep breaths

Mark 95 And how di how does it feel to you to do that, what's it like

AW 95 Uh not so not s not shaky once a time my hands used to shake and they ain't done that so much

Mark 96 okay what do you think that's about
 AW 96 Just taking like deep breaths and and doing them five count bits
 Mark 97 And that's all helped
 AW 97 Yeah that have yeah
 Mark 98 How is that for you to think about kinda you know deep breaths have
 helped how does that make you feel
 AW 98 Um er I know things will go right and at one time I didn't dare to wear my
 teeth when I went to centre or eat with them since we started in January
 um there's been about four four weeks that I've been eating with my teeth
 and I've eat with them going out as well so
 Mark 99 That's good what do you think has changed to let you do that
 AW 99 Um talking with Corrina about what to do and if I get panicky just count
 and take them out
 Mark 100 Right. What was it like talking to Corrina about that
 AW 100 Um fine fine yeah
 Mark 101 Mm were there any things you spoke to Corrina about that were really
 difficult
 AW 101 Death yeah
 Mark 102 What was it about death that made it difficult to talk about
 AW 102 Um sort of um at one time I didn't use to like talking about death... and I
 don't know don't know
 Mark 103 It used to worry you to talk about death but not anymore what do you
 think caused that change
 AW 103 Um just having someone different to talk to. Mm I ain't sorta had her for
 last couple of weeks that sort of seem strange not having her to talk to.
 Just don't know
 Mark 104 Mm okay Corrina talked to you a lot about what we call self-compassion.
 What does self-compassion how would you describe self-compassion to
 someone what do you think it means
 AW 104 I never heard of that before
 Mark 105 Okay about being kind to yourself
 AW 105 No I wouldn't harm myself. No I wouldn't harm myself that ain't worth it
 Mark 106 Why what do you think about that
 AW 106 Um I just wouldn't do that sort of thing
 Mark 107 Okay did Corrina help you to think better of yourself
 AW 107 Yeah
 Mark 108 How did she go about that
 AW 108 Um it was ages ago since she sort of like done that bit I think she done that
 when she first come here, I can't remember
 Mark 109 Okay do you think that you feel differently about yourself now to how you
 did before therapy
 AW 109 Yeah a lot better yeah
 Mark 110 You feel a lot better
 AW 110 Yeah a lot were I was when I first saw you last year I was really down and
 now I ain't. Sometimes I do but err that ain't very often
 Mark 111 You don't get down as often now what's that like
 AW 111 Um happy

Mark 112 Happy. When you do get down I think you were saying it's not the same now you don't get as down as you do before

AW 112 No only like if someone upset me or something but that's been alright

Mark 113 What other sorts of things would have got you upset before

AW 113 Um like I don't really know don't know

Mark 114 Do you feel different like you a different is there anything different about you the person who you are now is there anything different about who you are now because of the work with Corrina

AW 114 Um er happy for the things have gone right um I don't really know

Mark 115 But more able to be happy about the good things

AW 115 Yeah

Mark 116 Mm what how did that come about what do you think Corrina did that helped you to do that

AW 116 Um I don't know

Mark 117 Okay. If you were going to um.. you feel happier about some things. Do you feel differently about um kind of how you what am I trying to say I'm going to have to think about how I'm going to word this cos I'm asking such I know I'm asking really difficult questions and sometimes I have to think about how am I going to ask that so you can it can make sense um, do you think when things go if things don't quite go right do you feel differently about them now or do you think that's do you still feel as badly when things don't go well as you did before

AW 117 Mm um not so much as before

Mark 118 How has it changed

AW 118 Um... don't know. Bit hard question

Mark 119 Yeah okay what you have told me is that you're spending um you're spending more time with people at the centre now um and you've told me that that's kind of something to do with them being different people but I wonder if it's also about something to do with you feeling different about it. How do you think you feel about being with people now

AW 119 Cos um I'm next door twice on a Monday and a Wednesday and I'm not next door that's a lot better um people are better and uh we talk all all together and sort of have fun really or we're doing a job

Mark 120 Mm would you have done that do you think before you had the therapy

AW 120 No

Mark 121 No so how did the therapy help you to do that

AW 121 Um sort of being more comfortable with people n that mm I don't I don't know

Mark 122 Okay but something about being more comfortable with people. I wonder what that is I wonder what changed in therapy

AW 122 Don't know

Mark 123 Mm but it did something that helped you to feel more comfortable with people

AW 123 Yeah

Mark 124 What's it like I wonder what that's like for you if you could now go and spend time with people I wonder what it's like for you to do that

AW 124 Um I had um a month off after me operation and er I went back and told myself I was going to get on and do things but this timetable a lot different and uh people saying that I I look better and uh basically get on people

Mark 125 Mm how do you get on differently with people

AW 125 Um well talk to like new people who I ain't seen before uh there's a few on there what I ain't seen last timetable

Mark 126 What's changed then so why is why are you now talking to these people more

AW 126 Um sometimes you gotta speak before they speak to you sometimes

Mark 127 Yeah, Okay. So sometimes you'll speak before they do

AW 127 Yeah

Mark 128 What I'm trying to understand is why sounds like that's something you're doing now you're speaking to people. That's really good, but you probably maybe you didn't do that before you had all the therapy and everything

AW 128 No

Mark 129 So what's changed what's different

AW 129 Mm don't know

Mark 130 Okay. Was it something do you think that Corrina spoke with you about

AW 130 Yeah she spoke to me about it when she first started

Mark 131 Mm can you remember what she said

AW 131 No

Mark 132 Okay. You are doing really well with these questions I know it feels like they're really hard but you're doing ever so ever so well. Um, so finally let's come back let's come back to talk about Corrina a bit um what was it what did you think of Corrina herself what did you think of Corrina

AW 132 Really really uh really nice mm uh helpful what she did. I er to talk to. All I can sort of think of

Mark 133 If you were going to desc if you were going to tell your friend about Corrina, how would you describe her

AW 133 Sort of tall, I er told some friends at the centre and er a lot of them know her cos they um members told me that they're seen her uh one of my friends Amy who was on my Wednesday uh Monday one uh she came and saw Amy at next door on Wednesday on Monday one of the two anyway

Mark 134 Okay so it's like she's seen other people as well as you.

AW 134 yeah. And all the staff know um err Corrina as well

Mark 135 Good. Okay. What's that I wonder what that was like for you when you found out that lots of other people had seen Corrina as well.

AW 135 That uh I weren't just the only one. They even said she was good as well.

Mark 136 Mm yes yeah. I wonder if that made you feel any differently when you found out you weren't the only one

AW 136 Sort of relief really

Mark 137 Relief. How tell me about that tell me how you felt relieved

AW 137 Uh I know I weren't the only one what was uh what had seen her as well.

Mark 138 And how would you describe how she helped you.

AW 138 Um, don't know about that

Mark 139 If someone said to you um what did Corrina do then that was so good, what would you say

AW 139 Um that she helped me to talk about death and there were some of my friends that I talk about that with as well cos they told me that they do. And uh don't know

Mark 140 Apart from talking about kinda things I wonder if you did actually you told me you did tell me you did some drawings with her

AW 140 mm.

Mark 141 Um what were those drawings like to do

AW 141 Good you know

Mark 142 What can you remember about those drawings now

AW 142 Um I remember the first one I done where she drew like where there'll be a big cut under me stomach, drew like me laying in bed and er I get like cards and all that sort of thing and uh about um er sort what she done can't remember the other ones such a long while ago

Mark 143 Well try and see if you can remember any of them in particular can you remember if she did something about you feeling um uh feeling worried, feeling safe

AW 143 Um feeling safe when that girl sat um uh now picking on me

Mark 144 What happened tell me how Corrina worked with that tell me what you can remember about it

AW 144 Um sort of like um be calm uh ignore her and uh and tell like Tricia or staff at centre and uh can't remember what else was such a long while ago since think that was before Christmas that all that happened. I had all that happen last four months

Mark 145 mm. You've actually said a couple of times that it was all a long time ago now. I wonder does it I mean how does that feel to you does it feel like a long time or like it's all just flown by at all?

AW 145 Yeah time go too quick for me

Mark 146 mm. Tell me about that

AW 146 Uh I'm getting older. Uh um I'll be 48 in March. Um I'm alright if I keep busy. Now I've got a new carer that'll sort of now go busy I get so fed up though that's the thing

Mark 147 You get fed up. What is it that gets you fed up

AW 147 Um my sort of can't go out on the bus on me own. But now hopefully in April I'm going to be doing the bus training. So I don't know what date yet. I shall have a word with with uh Lucy on Monday did uh ask her when that actually is gonna be. I'm looking forward to it more this year than I did last year.

Mark 148 Okay, what do you think that's about why do you think you're looking forward to it more

AW 148 Uh I just want to get out with a couple of people uh at the centre and uh on the eighth we're going to the pic to see what's on at the pictures and uh sort of get out

Mark 149 Okay so something's changed there you feel more like you want to get out now

AW 149 Yeah

Mark 150 Whats that I wonder what it is I wonder what changed for you

AW 150 Um I don't know I think that's seeing all the other people do what they can do what sort of ask me tell me that I've gotta do it

Mark 151 Which other people are you referring to

AW 151 Uh my friend Tina she live in them um flats at the back and uh my friend Laura cos she come all the way from Diss and um she go on the train backwards and forwards so she gotta go anywhere and I thought if they can do it they can go all over the place they do

Mark 152 Okay so they do a lot of travelling and lot of getting about and you thought if they can do it then you can too.

AW 152 Yeah I ain't done it for three years. That'll be three years in June

Mark 153 I wonder why you thought cos okay so you haven't travelled for a while but your friends have been getting around like this all the time. I wonder why you thought that way now I wonder why now you're thinking well they can do it so I can

AW 153 I've uh I don't soon do it and they don't err do this bus training with me that uh I ain't gonna want to do it

Mark 154 Okay you feel like now's the time and if you don't do it now you might not want to do it another time

AW 154 Yeah

Mark 155 Why is now the time

AW 155 Um I want to get and do what I done before um uh get on the bus on me own come in on me own instead of going in a taxi. Um they go all round the houses before they can drop you home uh that's why I want to instead of going on it in the taxi

Mark 156 Okay. Um I'm not sure I understand perhaps you can help me understand why it's important this is something you want to do now but you perhaps even more than you wanted to do it last year

AW 156 Yeah um I think I was a bit nervous last year

Mark 157 Okay and you're not nervous this year

AW 157 No, no

Mark 158 Why not what's changed

AW 158 Cos I want to get out there

Mark 159 Right okay so it's about wanting

AW 159 Yeah have a look round the city

Mark 160 Right. Did you want to do that last year?

AW 160 No

Mark 161 Okay Okay right so why the question then is why do you want to get out into the city

AW 161 Uh to have a look about meet up with people instead of me mum coming with me. Uh I think that's cos I've come off about three different tablets uh make me want do more

Mark 162 Okay. I'm just gonna check. Mm I've lost track of time slightly. Um coming back to that's been a really interesting thing to talk about thank you, let's come back to Corrina was it easy to talk to Corrina about your worries

AW 162 Yes

Mark 163 How did you go about it can you remember

AW 163 Um sort of helping me do. I can't remember such a. I don't know

Mark 164 Okay. Were there any times can you remember when Corrina talked to you about things and you found it really difficult

AW 164 Yeah

Mark 165 mm. Can you remember any of those times

AW 165 Uh yeah like death uh but um when she came the next time I was alright after that. Where last year I couldn't talk about it or or anything

Mark 166 Mm and you've mentioned death several times now and I wonder how you feel differently about it

AW 166 I don't get angry that he taking everyone away and uh I don't see them anymore

Mark 167 You don't see them anymore

AW 167 No not when they die

Mark 168 Mm okay

AW 168 Um sometimes I say life uh not nice a bit sometimes. Taking so many people away. Haven't got anything else not a bit

Mark 169 So you feel differently about people that have been taken away

AW 169 Yeah

Mark 170 What do you think why do you think you feel differently about them

AW 170 Mm I had someone to talk to about it. I had someone to talk to like every every every week uh can't think nothing else. No can't think of nothing else on that one

Mark 171 Okay it was about just every week she came along she spoke to you and you were able to talk about it

AW 171 Yeah

Mark 172 And now that's come to an end and you're not seeing her anymore, what's that like

AW 172 Uh bit weird

Mark 173 Mm in what way

AW 173 Uh I can't talk to her and I might not I just um I don't want to go backwards again I want to go forward

Mark 174 And what would going forward be like look like for you how would you know if you're going forward

AW 174 Exciting um means that hopefully that I've done it uh

Mark 175 What is it that you will have done

AW 175 Bus training

Mark 176 Bus training

AW 176 Yeah Getting out there now the nights are now gonna start pulling in soon

Mark 177 Mm so what you're looking forward to is getting out into the world, seeing friends

AW 177 Yeah catching up. Catching up one of my friends he go to NANSA and he went like that when our friend Janet die and uh he done his so and he's now gonna go to join up for football season for next year he gonna join up for that as well he ain't done that for three years so

Mark 178 And what's it like that he's doing all of these new things

AW 178 Um pleased for him he phone me once a week and I phone him once a week uh I went to Parkside school with him I known him quite a number of years now I know he's done it I can do it

| | |
|----------|---|
| Mark 179 | Right he's done it so you can do it |
| AW 179 | Yeah hopefully when April come I can sort of get on on the buses and I did go ride with my carer up on the bus on Tuesday and uh bit nervous cos me mum weren't there but after that I was alright yeah |
| Mark 180 | What would it I wonder what's it like to think about doing that on your own one day |
| AW 180 | Uh be good that I'm doing it again that'll be me n mum went up the city the time before I said I used to walk up there with Jason and Janet and I used to go down there and go up there and mm then I'll be happy |
| Mark 181 | Mm okay how has it been what we've done today is talk about what it was like with Corrina doing all that work with Corrina. What's it been like to talk with me about it |
| AW 181 | Good |
| Mark 182 | Good what's been good about it |
| AW 182 | Uh talking about death um knowing that I can do it uh all like all different things what you said basically |
| Mark 183 | Okay well thank you |
| AW 183 | That's alright |

Appendix 11.

Transcript Three - GP

- Mark 1 So...right well what was what was it all like. What was it like meeting
Corrina and having your therapy?
- GP 1 That was quite nice yeah
- Mark 2 Mm. what would you say were the best things about it
- GP 2 Um we talked about like making imagination room for myself so I could go
out n about and like distracting myself kind of thing
- Mark 3 Okay. How did what do you think were the most important things you
learned from it
- GP 3 Um try and like distract myself so I could go out on my own kind of thing
with the kids which I've done and been on my own on the bus kind of thing
- Mark 4 Right okay cos when we first met you hadn't really been out at all had you
- GP 4 No
- Mark 5 So what was it like to go out
- GP 5 Um that was alright yeah I just like distracted myself kind of things so if
someone was walking past I'd do my shoe or something to see what they
were up to so yeah
- Mark 6 Cool you're smiling as you say that
- GP 6 Yeah
- Mark 7 I can imagine. It's been a long time since you've done that hasn't it
- GP 7 Yeah quite a while yeah
- Mark 8 Mm... good thing. How did the two of you get on
- GP 8 Quite well she was quite nice yeah
- Mark 9 Mm okay and what do you think were the qua how do you think she helped
you
- GP 9 Um she just like talked me through what to do. Like she'd do the same like
if someone was walking past she'd fiddle with something kind of thing so
yeah
- Mark 10 Okay. So what do you think was good about the therapy
- GP 10 Um that helped me a lot to get the kids out and about with me like to the
park and on the bus and that so trying to like do one at a time kind of thing
- Mark 11 mm. Okay and what do you think was not so good about it
- GP 11 There weren't nothing
- Mark 12 Okay it was a all round good experience
- GP 12 Yeah
- Mark 13 Were there parts of it that you found quite hard.
- GP 13 Um just like walking on my own to the shop I did find hard yeah so I used to
just take one of the kids with me so that was easier
- Mark 14 Yeah so you broke it down a little. Mm and what about the work you were
doing when Corrina was here was there anything that she spoke about with
you that you found hard
- GP 14 No
- Mark 15 Okay. And were there any parts that you found easy
- GP 15 Uh just going out really that was quite easy
- Mark 16 Mm okay. I think I know the answer to this one has your therapy helped
you

GP 16 Yeah

Mark 17 Right. Describe how for me

GP 17 Um think like cos we met at the doctors and I was walking by myself and Paul didn't have his car so that helped me cos he didn't have a car kind of thing

Mark 18 Right. You had to go

GP 18 Yeah

Mark 19 Okay. How do you think you've changed. I know you're doing different things but how do you think you have changed as a result of the therapy

GP 19 Um. Not so much nervous of people kind of thing and more happier

Mark 20 Mm and what do you think that's down the happiness is down to

GP 20 Um going out and about with the kids so

Mark 21 Yeah okay. How would you describe the work that you did with Corrina. How would you describe that to a friend

GP 21 Um I dunno. Uh quite that was easy but I suppose everyone's different so I don't know.

Mark 22 mm. what do you think would be if you were going to try and sort of say what happened, what what what couple of things would you say

GP 22 Um the room helped me think of imagining room kind of thing um cant think of anything else

Mark 23 Okay tell me something about that room

GP 23 Um we made up like a room so I could think of a comfy room so when I was walking about I could imagine I was sitting in a room with a big TV and a bed and units and that in there

Mark 24 Right. A place that you could go and feel safe

GP 24 Yeah a place feel safe by myself

Mark 25 Mm okay and you found that you would you used that when you were out and about

GP 25 Yeah

Mark 26 Okay. So how did you develop that room

GP 26 Uh just imagine like sitting in it kind of thing. So like if I was nervous walking down the round I'd kinda imagine that I was there but I'm not kinda thing so it was a little bit hard but then I kinda distracted myself by if a bloke was walking past I'd just like look over so I could look over me shoulder once she taught me to look over once kind of thing to see where he was going or so I didn't get so nervous when he was going past

Mark 27 Mm cool okay. If someone you knew was feeling anxious, what would you suggest they do

GP 27 Make a hot drink she taught me and like staying indoors I'll be always get anxious I've done that quite a few times up to an hour Paul left me and I just make a hot drink or watch telly or I'd go on my facebook so that distracted me

Mark 28 Mm find things to distract you

GP 28 Yeah

Mark 29 Mm so you don't sit there and just think about it. If we could just kind of reduce your therapy to one thing that you did or one thing that was really important about it what do you think that would be

GP 29 Uh staying indoors by myself

Mark 30 Mm being able to do that

GP 30 Yeah

Mark 31 mm. Okay and if there was one trick or one thing that Corrina taught you that really helped you do that what would it be

GP 31 Um I'd like do my breathing kind of thing that realx me and then I'd make a hot drink and watch telly

Mark 32 Okay so the breathing to relax and then something to distract you. *(At this point her son came and stared at us through the window for a few seconds – we notice him and chuckle)*Um okay tell me more about the breathing and how that helped you

GP 32 Um that helps like your heartbeat to slow down kind of thing and then once I've done that I just like wander about and make sure the doors are locked and things like that she taught me

Mark 33 Mm Okay. What was it like doing the breathing exercises

GP 33 They were alright yeah they helped a lot the kids used to sit there and laugh when I used to do it in front of them

Mark 34 Yeah. Did you ever try to get the kids to do it

GP 34 Yeah they tried some but they wouldn't do it

Mark 35 Ah that's a shame they're really good for kids if you can get them doing them but it's really hard work to get them to do them. Okay but so the kids were having a bit of a laugh about it but were you still able to do it

GP 35 Yeah

Mark 36 That's good yeah good. So this was all about you being anxious and not wanting to be on your own and not wanting to go out on your own um I think you've answered told me a lot about this but how has that changed since you met Corrina

GP 36 That's changed quite a lot cos I take the kids out on me own I can like I was walking Rhianna to school by myself say and I was walking to meet Katrina by myself so that's helped a lot yeah

Mark 37 So you are going out with the kids just with you and the kids but you're also going out just with you on your own now

GP 37 Yeah

Mark 38 Are you still doing that now you're not meeting Corrina

GP 38 Sometimes yeah

Mark 39 Okay just checking it's important to keep it going. Um so we know what you're doing differently you're going you're going out on your own but how does it feel differently

GP 39 Um I dunno it just just the way she taught me it just feel different to me kind of thing

Mark 40 Can you try and describe that for me

GP 40 Um I just feel like no one's gonna hurt me kind of thing and when I was walking about there weren't like massive lot of people about so that was like quite easy

Mark 41 Mm Okay when you'd gone out I'm interested in that thing about people not wanting to hurt you can you tell me more about that

GP 41 I just like kept an eye on what they were doing kind of thing and I just noticed that they were just normal people just like walking the dog or going to the shop or somewhere. Or I'd always make sure I carried my phone if I needed Paul or anything. Make sure I had credit on there yeah

Mark 42 And what about things like the using the room and breathing and so on

GP 42 Um just using the room I just used to imagine that I was on my own

Mark 43 Okay okay what was it about so you came to notice that people were just ordinary were just people. What was it do you think about the therapy that helped you to do that

GP 43 Um mainly the breathing I used to do before I used to go out um just looking over my shoulder once helped me so I knew where they were going kind of thing or I used to stop and 'tend I was doing something so I could watch where people were going

Mark 44 Okay do you still feel anxious sometimes

GP 44 A little but not as much as I used to

Mark 45 mm. So can you describe that difference for me I know that's a very difficult question

GP 45 Um I just feel different I don't know why I think Corrina helped me a lot with the breathing and the room I don't know 'at just felt like a weight lifted off my shoulder kind of thing so when I was walking down the road with the kids I just felt I don't know that no one would harm me kind of thing so I don't know

Mark 46 Mm like no one would harm you

GP 46 Yeah

Mark 47 And what was that like to think to have those different thoughts

GP 47 Um well that helped quite a lot that cleared my head quite a lot so like she made me I can't think what it was think of like if someone was looking at me and I notice they were looking she made me think that they were looking at me cos I was sexy or pretty kind of thing so that help yeah so like think of the opposite kind of thing

Mark 48 Right it may not be that they're looking to hurt you okay cool and um... I've forgotten what I was going to ask what was I going to ask you I had a question in my mind and now it's gone... I'm trying I suppose what I'm trying to think about is that, that idea that you feel less anxious now you've described how you kind of you don't see everyone as being threatening but maybe now you realise they're just ordinary people and um and you've got you know your room that you can go to in your head and so on so you've given me a good explanation of all of that but I'm still interested in this idea that your anxiety is different now to how it was before you know it's not like you aren't ever anxious I've got that impression there's still some anxiety there but I'm trying to understand how you know what how does it feel differently now

GP 48 I don't know it's just hard to explain kind of thing

Mark 49 Yeah I know I know that it is but I'd be really interested if you could try

GP 49 I just I dunno I just felt like I could go out kind of thing and that I when I done my English kind of thing I felt cos I passed my first one and I'm waiting

for my next one to come through that made me feel like I'm not different from everyone else

Mark 50 Oh right good so what was that like to pass those

GP 50 I was kind of like excited cos that was like the first test I've ever passed kind of thing and I'm waiting for my entry level three so and I'm now going to go for another course to work so I can pass to work with kids so that's like the entry level one

Mark 51 Cool so life is really moving on for you isn't it there's lots of change happening but I was interested in that comment you that uh it made you feel like everyone else. Tell me more about what you meant by that

GP 51 Just felt like normal for once like everyone else just walking about kind of thing. I still like keep an eye out over my shoulder just in case but not as bad as I was kind of thing

Mark 52 Mm yeah just like everyone else

GP 52 Yeah

Mark 53 What's that like to think about

GP 53 Uh just being like normal kind of thing

Mark 54 So if you're now normal what were you before

GP 54 I just felt different kind of thing like I was stupid from everyone else kind of thing

Mark 55 Okay mm and you don't feel you don't feel that so much now

GP 55 No

Mark 56 No. Very cool... we've started to talk about self about the self-compassion ideas and about whether you feel different from everyone else or the same as everyone else, um what do you think self-compassion means to you now

GP 56 Um we can all do things the same kind of thing and no-ones different

Mark 57 Mm okay do you think how is that kind of what how is how has what you think of as self-compassion changed from before you started. What do you think you would have described it as beforehand

GP 57 Um that I was different from everyone else kind of thing uh and just like a failure kind of thing on my tests

Mark 58 Yeah... you felt of yourself as a failure

GP 58 Yeah

Mark 59 And is that I'm getting the impression that's not something you now think

GP 59 I do now and then but not a lot as much as I used to

Mark 60 Okay so it's gone down

GP 60 Yeah

Mark 61 mmm.. I might I don't want to put words in your mouth here you were a failure but now you're more like everyone else is that

GP 61 Yeah

Mark 62 Am I getting that right or is it kind of

GP 62 Yeah

Mark 63 Okay.. how do you think the therapy helped you to figure that to kinda change how you felt in that way

GP 63 Just like taking the kids out and about and doing my courses kind of thing and meeting new people making new friends kind of thing

Mark 64 mm... Helps you to understand that you're more like other people

GP 64 Yeah

Mark 65 But what was it about the therapy then that helped you to be able to do those things in the first place

GP 65 Um like the breathing kind of things I done and thinking of the room where like if I was on a test I'd think of that room kind of thing then I'd know that I'm in somewhere safe kind of thing

Mark 66 Okay so you had somewhere safe a way of feeling safe

GP 66 Yeah

Mark 67 And that allowed you to begin to do some new things

GP 67 Yeah

Mark 68 And realise that actually you're not that different

GP 68 Yeah

Mark 69 Mm, okay if you had to try and explain to a friend about the self-compassion, what would you say

GP 69 Mm don't know... um trying to think. I don't know... Can't think of anything

Mark 70 Okay. Are there any other, we've talked about self-compassion from this idea of whether you're different to everyone else or just like everyone else where there any other parts of self the self-compassion conversations that you think were particularly helpful

GP 70 No

Mark 71 Okay... I think we answered most of most of those... your sense of sort of compassion and your sense of self-compassion, can you describe how you felt that change what it was like to feel that changing during the therapy. What was it like when you began to think differently about yourself

GP 71 Um I felt more happier and more I had more energy kind of thing to get up so

Mark 72 So alright okay so you had you felt happier about yourself. Tell me more about that

GP 72 Um I just the kid I used to be like quite moody kind of thing cos I always used to put myself down and didn't like going out the door but now I just I don't know I just feel more happier kind of thing cos I can just know I can go out and about with the kids

Mark 73 So can you give me some examples of ways that you would put yourself down

GP 73 Um I thought I was like cos I've got learning difficulties I thought I was thick kind of thing but then after passing me English I knew that weren't I was not different from anyone else kind of thing cos there was other people in there from nearly the same levels so

Mark 74 We all have experiences of passing things and of failing things. We all have those experiences sometimes

GP 74 Yeah

Mark 75 Okay so you started to feel more kind of more like you were like other people. You talked about meeting other people there but of course that means meeting meeting new people

GP 75 Yeah

Mark 76 And that was something you told me you found difficult

GP 76 I struggled with yeah. Cos um I can go in a room if there's loads of girls that's just weird but if there's boys I won't go in but now I can just go in kind of thing cos that's like English was like mixed so I just yeah I sat by myself but and then I started moving onto the other tables the English teacher moved us so then we all used to talk in a group kind of thing so I got used to that

Mark 77 What was it like the first time you went

GP 77 Um I used to hide in the corner kind of thing to do my English work but now once I got used to the mums and dads I could sit on their table and they all used to make me a hot drink as well so yeah

Mark 78 Okay you got your hot drink to feel relaxed mm. That first time you went must have been a quite a tough quite a worrying thing

GP 78 Yeah it was that took me a year I think to actually move onto the other tables with the other parents so yeah that took em ages to get me into English so and my little boy's now eleven and that's took me that long so yeah

Mark 79 Do you think the work with Corrina helped you to do that

GP 79 Yeah helped me a lot

Mark 80 Mm explain to me again how you think that worked

GP 80 Um just the thinking the things like different when people are looking at me and I can't remember the other one what she taught me

Mark 81 When people look at you how does that work for you now do you what sort of thoughts would you have had in the past

GP 81 Um like gonna harm me kind of thing but now I just like look n just carry on walking kind of thing or if I'm sitting in English and they're looking I just I pretend I'm writing so just distract myself sort of thing

Mark 82 Mm okay do those those thoughts about maybe they're going to harm me are they completely gone or a little bit of work

GP 82 They're still a little there in the back but not a lot kind of thing I just cos she taught me to say it um go over three times to say that I'm okay and I'm safe kind of thing so to do that sometimes I used to do it walking down the road but cos I didn't think I was speaking out loud and I seen people looking cos I was going I'm okay I'm safe carry on walking and I think a woman must have thought I was talking to myself so I'd like try to just mumble it in my head kind of thing yeah

Mark 83 Okay so you're kind of the self-talk of I'm okay I'm safe made you look different and stand out. What was that like when someone suddenly was looking at you and you realised what had happened

GP 83 I just went quiet kind of thing and then I realised that cos I was speaking loud I just like mumbled it so like no-one couldn't hear me when I was walking along the street kind of thing. Yeah

Mark 84 I can imagine a different time a different person might have found that quite that might have been quite a setback for them to realise that had happened

GP 84 Yeah

Mark 85 But you're almost smiling about it

GP 85 Yeah it don't seem to bother me so

Mark 86 Which is a really good thing
 GP 86 Yeah
 Mark 87 It'd be easy to imagine someone having that happen to them and thinking that's it
 GP 87 She did try to get me to walk along the street with uh headphones and music and I said no cos then I'd sing out loud and then everyone would be looking
 Mark 88 *(laughs)*
 GP 88 I said no no way
 Mark 89 Alright well maybe that's one you could try another day it doesn't have to you can go when you feel ready you can give that one a go
 GP 89 Yeah
 Mark 90 But you'd feel your fear would be that you'd speak out
 GP 90 Yeah
 Mark 91 You'd suddenly start singing to some really embarrassing pop record or something
 GP 91 Yeah the kids would be laughing
 Mark 92 Yeah one of their favourites comes on and you're singing to it oh dear yeah. When you think about doing that when you think about laughing out or doing that and people sort of seeing you and laughing at you what does it feel like to think about that
 GP 92 Just feel good kind of thing
 Mark 93 Feels good
 GP 93 Yeah
 Mark 94 In what way
 GP 94 I don't know I just cos I've seen like people before like walking and like talking to themselves kind of thing and I used to be like kind of scared of them but there's one bloke what always used to walk his dog and I can walk past him now so like kind of thing cos Rhianna likes dogs so she'd lean out the pushchair and then he'd start talking to me and I started talking to him cos Rhianna like dogs so she'd lean out and say hello doggy so I get a bit frightened when someone come close kind of thing but now I just he just said hello and I said hello so and just carried on walking so yeah
 Mark 95 What's it like when you recognise those little moments about yourself where you've changed
 GP 95 I feel more happier kind of thing. Lately the kids have noticed I think quite a lot
 Mark 96 What have they noticed
 GP 96 That mummy's more happier and I can take them out kind of thing to the shop they like that so they can get their sweets and books
 Mark 97 Yeah okay yeah they're kids as long as there's sweets in it or something they're alright aren't they what do you think they notice is different how do they know that you're different
 GP 97 Uh I think my Tommy's noticed more because he I think that that was rubbing kind of thing like when we were walking through the cut he'd run back home cos he didn't want to walk with me he wanted Paul but now because I only look behind once and he's noticed and I carried on walking

without like going back home and I just walk straight to the garage and he's noticed that I been walking on my own kind of thing that mummy's changed that I don't need daddy all the time so yeah

Mark 98 So he sees you being a bit more independent

GP 98 Yeah

Mark 99 Mm what's that like for you

GP 99 That's more easier yeah

Mark 100 mm... what do you think they thought beforehand

GP 100 Uh I think they just thought I was like they kept asking me mummy scared kind of thing and so like questions what happened but you didn't really want to tell them kind of thing so yeah but no cos they knew I was going to therapy and the lady was helping me get out I suppose they knew that I was getting help kind of thing

Mark 101 Mm and what's it like for you to be able to do those things for your kids now

GP 101 I feel I can do it on my own now so it's more more better kind of thing cos I used see the mums walking their kids to school on their own and I always used to think oh I want to be like that n now I can so yeah feels good

Mark 102 Sure what was it that was stopping you that was making you not like them

GP 102 Uh cos I always had Paul with me so everywhere I went Paul would walk with me kind of thing cos I was too nervous to like walk to the Doctors or that

Mark 103 Mm and I have to just comment that you've basically smiled your way through this entire meeting today and I remember when we met before your therapy that that's not what you were doing that wasn't that wasn't how I experienced being with you last time you weren't smiling your way through all the time and that's a really big change

GP 103 Yeah

Mark 104 Very cool... so let's talk a little bit about Corrina. What was it like working with her

GP 104 That was easy because that was a woman. I don't know I don't know if I could have done it with a man I don't know so might have just been a little bit harder and then I'd have just got used to it kind of thing but no she was quite good yeah

Mark 105 Mm, what was it that was good about her

GP 105 Uh she always welcomed you kind of thing and always made me a hot drink so

Mark 106 I'm noticing that that hot drink thing yeah. Okay um... so why can you try imagine if it had been the other way round. Imagine if Corrina had come and done the first if Corrina had come and met you to start with and then it had been me that had been doing the therapy with you instead. How would that have been different

GP 106 Um I don't think I'd have gone in the room I don't know

Mark 107 That's very honest I know what I understand why

GP 107 I don't know I just that's just weird but I have got used to like some of the dads in me English so I'm slowly getting there

Mark 108 What's that been like to do

GP 108 Uh quite hard but then you just notice that they're just there to learn kind of thing

Mark 109 Mm and what was what was happening beforehand

GP 109 Um I'd used to just sit on me own kind of thing in the corner

Mark 110 Mm and what would you think about the dads

GP 110 Um just like would they harm me kind of thing and then I'd just like started moving over to the tables cos we used to mix we used to do like we had to pass like the reading and writing and the speaking one so I'd just got used to talking and then we used to mingle in the group so but kind of thing is we had to go in the groups which she put us in so that was hard but yeah

Mark 111 Did she push you into those groups beforehand

GP 111 No

Mark 112 Okay

GP 112 yeah

Mark 113 Mm and so beforehand you were kind of thinking um I wonder whether they're going to harm me I wonder if that's what they're thinking. But then in time you came to see that they were just there to learn just like you were

GP 113 Yeah

Mark 114 Um and part of that was about the teacher doing actually doing something that really helped which was getting you to sit on a table with them and mingle with them. But I wonder what that was like I wonder if you can explain more about what that was actually like to do try and explain that experience for me of being sat down on a table with a dad that you didn't really know

GP 114 It was quite nerve wracking took me a little while to speak in the group but then I realised I had to speak cos if not I wouldn't have passed so if I didn't like speak and mix in and do like whatever task she gave us I wouldn't have passed that level and I'd have to do it all over again so then I just think I just got the courage to do it so I could just get through it to pass it

Mark 115 Where did that courage come from

GP 115 Don't know I just started speaking kind of thing. I think it was because I wanted to show the kids that I can that we can all do it kind of thing. So if they're in tests or anything and they fail kind of thing they can do it again

Mark 116 mm. about being a model for your children

GP 116 Yeah model

Mark 117 mm... if you hadn't done the work with Corrina do you think you could have done that do you think you could have spoken in that group

GP 117 No

Mark 118 You're quite sure about that aren't you

GP 118 Yeah

Mark 119 Why why why so sure

GP 119 I don't think I'd have mingled kind of well no she helped me a lot Katrina did yeah I don't even think if she didn't help me I don't even think I'd have even gone out the house kind of thing so yeah

Mark 120 ... what do you when you were first thinking about mixing mingling with one of the dads on the table never mind about speaking in front of one of

them was there anything of the work that you'd done with Corrina that you were that was helping you
 GP 120 Uh just thinking like imaginary room or I did do one with the woman before stone? Imaginating like a shell kind of thing that you talk to kind of things like that helped yeah
 Mark 121 So you were using the room again
 GP 121 Yeah
 Mark 122 How often do you um think about the room
 GP 122 Uh not a lot so much now if I'm doing something where I'm busy I don't really think about it so it comes I sometimes if I get nervous then I think about it and then I'm alright yeah I don't really think about it a lot so if I'm playing with the kids I'm alright kind of thing long as I'm busy
 Mark 123 How nervous are you now?
 GP 123 A little
 Mark 124 Okay, have you thought about the room while we've been together
 GP 124 yeah
 Mark 125 And has it helped
 GP 125 Yeah
 Mark 126 Mm good okay... again I'm thinking about Corrina personally now what was good about working with her
 GP 126 Um she make sure that I done something like three times and she kept pushing make sure that I do it kind of thing so if I had like night time I'd do an hour was my last one for Paul to leave me on my own I had to do that three times before I got used to it kind of thing we used to draw faces um one used to be right anxious and then little and then more and I was in the middle all the time so she knew that I was kind of getting better but I was never like on the first one I was always in the middle face so yeah
 Mark 127 And she was kind of encouraging you to keep trying those things
 GP 127 Keep trying yeah I had to do it three times so then she knew when the faces moved along kind of thing I think that took me that took me five attempts to do one to sit on my own one of them because that the night time was the hardest because I didn't like being left in the dark so that one I had to do five times cos I had to get used to it kind of thing but the going going out we done like once or twice kind of thing on that one and I could move up to the next ladder on the step kind of thing
 Mark 128 When you were having when it took you five tries to be able to be alone when it was dark, what was that experience like for you of having to keep practising that to get better
 GP 128 uh was first go I was a little bit nervous I kept walking up and down and making sure the everywhere was locked and the curtains and Katrina taught me if someone knocked on the door and Paul weren't there just to peek through the curtains to see who it is kind of thing but I so used to where I if someone do knock I don't go to the door night times I just wait till the morning kind of thing. If Paul was here yeah then I'd answer the door but I do I have once or twice when Paul weren't here and someone's knocked and I have answered but it's very rare I do I just panic just in case

Mark 129 So it's still a bit hit bit kind of up and down that one isn't it it's been a bit more of a challenge for you to get to get the kind of being alone when it's dark sorted out and of course now it's the middle of summer so it's you can't really practice it so easily but um I was wondering what it was like you know you found that one more difficult, how did you make sense of that what did you think about the fact that you were finding it more difficult

GP 129 I think it was being left on my own kind of thing and because once before I think Paul used to go fishing night fishing and I think the boys up the road cos the knew I was on my own they knew I was nervous cos they knew my brothers and they used to knock on the door and torment us so I rang the police kind of thing so that made me nervous kind of thing I think they were just like messing about so that made me nervous to go to the door if anyone knocked or anything but now I just I sit here and just like watch telly and make a cup of tea and if someone knock I just say like who is it and then kind of thing or I look through the curtains to make sure I know them

Mark 130 ... so you're getting better at it still got a bit more getting better at it to do. Um how is it to know that you've still got some you're not there yet you haven't quite got it all sorted out

GP 130 It's not too bad but I'm just like keep practicing it but got to wait until it get like dark again to practice a bit more kind of thing

Mark 131 Yeah it's a bit of a problem in the middle of summer isn't it are there any of the other things that you're doing that you're finding difficult

GP 131 No just that one

Mark 132 Does that I'm I suppose what I'm trying I'm trying not to ask you this directly but I give up I'm going to have to ask you it directly um is there any way in which it feels a bit like you failed at that or you've let yourself down in any way

GP 132 No cos I done an hour on my own so I was quite chuffed with that me n 'trina so yeah

Mark 133 Okay fine there's no sense of being a failure. Good um... we may have sort of answered the next one we were talking about how she really helped you and you talked about how she gets you to do things several times but I also wanted to ask you know what was difficult about working with Corrina what was hard about it

GP 133 Um when she kept pushing me to do the night time one so yeah

Mark 134 I thought we'd probably already answered that one so it was good that she gave you a bit of a push but then on that one she was pushing you quite a bit

GP 134 Yeah

Mark 135 Why did you let her do it

GP 135 Um I think that was cos she was helping me kind of thing so I knew that she was trying to help me to get used to sitting on me own kind of thing so but she knew when I hadn't done it cos I wouldn't get that ladder out first so she'd knewn that I didn't give it another go kind of thing

Mark 136 So there were times when you didn't try it

GP 136 Yeah

Mark 137 Okay, you were just a little bit quieter there as you said it
GP 137 Yeah
Mark 138 You got caught out you got rumbled mm what was that like
GP 138 Um I felt stupid and then I thought to myself that I can do it and then I just like started doing it but it just took me a little longer to because she used to say three times but we done it five times so I got used to it in the end kind of thing
Mark 139 When you say you felt a bit you felt stupid and then you decided you could do it um I know that you said earlier that you used to feel like because you have learning difficulties I'll use your words because you have learning difficulties you were thicker than other people, which we know isn't true
GP 139 No
Mark 140 But you also just said there that you felt stupid when you hadn't done the exercise are we talking about the same thing there or something different
GP 140 Um it's kind of the same but I just felt stupid cos she found out that I didn't do it kind of thing
Mark 141 You got caught
GP 141 Yeah so then I just like got on with it kind of thing cos she was alright but she was a bit bossy so she pushed me kind of thing she was alright
Mark 142 Okay you got a bit of a nudge I'm wondering about some of those compassion ideas around um you know you didn't do something but we all sometimes don't do things and I wonder where you would have felt the same way before meeting Corrina if something like that had happened
GP 142 Mm no I don't think I would have done I think it was cos I had someone there pushing me kind of thing to do it someone so I found that more easier kind of thing I think if Paul was more like that if say go to the shop on your own then yeah
Mark 143 Right okay I don't know if we dare tell him that cos then he might start doing it and you'll have to do all these things!
GP 143 Yeah
Mark 144 Alright so she was really good cos she kinda she gave you that push and maybe you haven't got anyone else in your life who does that for you at the moment who keeps pushing you
GP 144 No
Mark 145 Okay. Um so I wonder what that was like to find yourself suddenly having someone pushing you along what was that like when that started happening
GP 145 It was weird but then I just got used to it kind of thing so
Mark 146 Mm I wonder when it first happened what sort of thoughts and feelings you were having
GP 146 Um I was just a little bit scared but then once I knew she was trying to help me kind of thing I was alright
Mark 147 Okay. Again I think we've probably drifted into answering this one but I'll ask anyway, how would you describe Corrina to somebody
GP 147 Um a little bit bossy um make a nice cup of tea and she was quite nice yeah
Mark 148 Okay... did you feel safe with her
GP 148 Yeah

Mark 149 How do you think what was it about her that let you feel safe
 GP 149 Um. I think it's cos we met like in the doctors kind of thing so like a public
 place so yeah made me feel more safer kind of thing
 Mark 150 mm... okay public places for you have been difficult in the past so I'm a bit
 try and help me make a bit more sense of that
 GP 150 Um I used to be alright like going in the doctors cos I used to take the kids
 on my own a lot when they were ill. I did used to panic if it was too packed
 but and then I used to just sit down kind of thing I'd always make sure
 there was a space where no one else was sitting but if it was the kids ill I'd
 go in but if it was me I had to take someone with me kind of thing at was I
 don't know suppose I was worried cos the kid was ill so that was different
 Mark 151 Mm but you didn't worry so much for yourself okay what about now
 GP 151 I'd take myself yeah
 Mark 152 What's that like to think about
 GP 152 Um at's alright yeah if it's not too packed I'm usually alright but now I cos it
 get packed in the doctors I just sit there and wait for my appointment so I
 just sit there and play on my phone on the games or anything to distract
 me
 Mark 153 Mm, what do you think about that as a it's kind of like in the past you
 wouldn't have you you wouldn't have been able to look after yourself by
 going to the doctors when you were feeling poorly but now you could look
 after yourself by going to the doctors. I kind of want to ask you do you
 think you deserve to be looked after
 GP 153 Yeah
 Mark 154 Yeah does it truly feel like tis okay to go to the doctors. Does it feel a bit
 strange
 GP 154 It feel it did feel strange first go off but then I was thinking everyone else is
 there cos they're ill kind of thing so that just felt right yeah
 Mark 155 Mm they're all ill too
 GP 155 Yeah
 Mark 156 mm... hopefully except the doctors yeah okay... What was it like talking
 with Corrina about your anxiety
 GP 156 Um at was more easier cos she was a woman kind of thing I find it like hard
 when I go into the doctors if that's a man I won't speak kind of thing so
 that's why I used to take Paul with me but now I can just go in and tell
 them what's the matter so yeah
 Mark 157 What again I'm interested in what that was like when you realised you
 could do that
 GP 157 It just felt good kind of thing just felt like I can I can do it all the time kind of
 thing
 Mark 158 Mm and as you look back now on how you were before, what's that like
 GP 158 'at just seem weird kind of thing that I was that scared kind of thing
 Mark 159 I wonder whether you look back at it and feel a bit sad about it or just feel
 like sorry for yourself or
 GP 159 I just felt a little sad but then I just get on with it kind of thing
 Mark 160 Mm and as you think about how you are now what's that like to think
 about

GP 160 More happier kind of thing
 Mark 161 mm... if you could something to yourself kinda six months ago or before you met Corrina what would you say
 GP 161 Uh... I didn't really say a lot about myself kind of thing just thinking that I was thick kind of thing and different from everyone else kind of thing
 Mark 162 Mm and what would you say to that person that thought those things
 GP 162 I was stupid kind of thing yeah
 Mark 163 Mm I know what you mean but its I think I know what you mean what would you tell them to think instead
 GP 163 That I'm not different from anyone else kind of thing
 Mark 164 ... when Corrina began to talk about anxiety and talk about self-compassion and so on was that easy or difficult
 GP 164 I found some of it easy and some difficult
 Mark 165 Tell me more
 GP 165 But then I just realised she explained to me kind of thing how your brain work kind of thing and she did she drew a person on a paper and that and shew me like how the brain thinks and you need to work it down somehow
 Mark 166 Can you remember much about those drawings
 GP 166 No
 Mark 167 I'm not going to give you a pen and paper okay did you find it helpful or confusing
 GP 167 Helpful yeah
 Mark 168 In what way was it helpful
 GP 168 Uh to work out she drew like your heart beating kind of fast and then done a different picture later to show me how like I've changed kind of thing were my brain slows down thinking that people's gonna harm me when they're not kind of thing
 Mark 169 mm... when she began to do that and she was beginning to think about self-compassion how did she describe all of that to you
 GP 169 Um can't remember... I remember one of them having like where my heart used to beat fast but when I walk like past people now we drew one where it didn't beat or anything or my hands used to sweat they just like normal kind of thing when I walk past people cos I think of that room so that calms me down kind of thing
 Mark 170 Keep coming back to that room don't we so many times ... mm what did you think when Corrina first said we're going to imagine a room
 GP 170 I did feel weird but then I just thought all the stuff in it kind of thing yeah
 Mark 171 And when you were explaining it to others what did they make of it
 GP 171 They thought that was weird but then that helps me kind of thing so yeah
 Mark 172 So you think it's a bit weird but if it helps you it's okay
 GP 172 Yeah
 Mark 173 Has anyone else thought it would be a good idea for them to try
 GP 173 No
 Mark 174 No. Funny thing to explain to people
 GP 174 Yeah

Mark 175 If you could talk to someone else who was feeling how you felt in the past, what would you say to them

GP 175 Mm I'd most probably try n help them like Katrina's helped me kind of thing. Do the room or the breathing exercise with me so yeah

Mark 176 Okay so you'd do the rooms talk about the rooms the breathing exercises. Are there any things you'd want to tell them

GP 176 No

Mark 177 What would you tell them about getting help with it

GP 177 That was quite good yeah

Mark 178 Mm
(her phone rings – it is the school saying that her partner needs to pick up their daughter. We are interrupted by making arrangements for her partner to head out and by one of her children coming into the room)

Okay um yes so we were imagining this person who was feeling how you did in the past and thinking about what you'd say to them and you described the breathing exercises and you described the room. What else would you say to them

GP 178 Um I'd just mainly that what helped me the room and the breathing uh depends what they had problem with kind of thing

Mark 179 That's true everyone gets different things from it and that's why I'm so interested in what you got from it because it's helpful to hear the real stories. Is there anything else you'd want to say about everything you've gone through in the last few months

GP 179 no

Mark 180 ... have there been any parts of it that you haven't liked

GP 180 no

Mark 181 Any parts of it that you'd found a bit useless

GP 181 no

Mark 182 No were there any times when Corrina was here and talking to you and you were thinking okay she's talking a bit of rubbish now

GP 182 Not really she helped me quite a lot so

Mark 183 mm. Okay any final thoughts anything else to say

GP 183 No

Mark 184 No okay well we're done on that then. Stop this.